Plaintiff's
Trial Exhibit
No. 2

UNITED STATES DISTRICT COURT
SOUTHERN DISTRICT OF NEW YORK

DISABILITY ADVOCATES, INC.

Plaintiff,

- against -

NEW YORK STATE OFFICE OF MENTAL HEALTH ("OMH"), et al.,

Defendants.

02 Civ. 4002 (GEL)

Report of Plaintiff's Expert Dr. Terry Kupers, MD, MSP

June 1, 2005

Confidential

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Executive Summary

The most striking feature of mental health services in the NY prisons I toured is the large number of prisoners suffering from serious and persistent mental illness (henceforth referred to as "serious mental illness" or "SMI") who are housed in some form of isolated confinement, where they are kept isolated from other prisoners, have minimal contact with staff, spend nearly 24 hours per day in their cells, participate in very few if any programs, eat alone in their cells and are mostly idle.

It has been known for as long as segregated housing has been practiced in prison that human beings suffer a great deal of pain and mental deterioration when they remain in isolated confinement for significant lengths of time.

As I will explain below, it is my strong professional opinion that prisoners with SMI should not be housed in isolated confinement (SHU, Keeplock, Administrative Segregation or Protective Custody when it involves lockdown),[1] and that the isolation and idleness of observation should be ameliorated because:

- isolated confinement tends to worsen the prisoner's mental illness and prognosis;
- prisoners' mental impairments prevent them from remaining free of disciplinary infractions long enough for them to gain release from isolation; and
- prisoners with serious mental illness need more intensive mental health treatment and programming than is available in isolated confinement settings.

For prisoners with serious mental illness, the consequences for unacceptable behaviors must be determined in the context of mental health assessment, diagnosis, and treatment. This requires a high level of collaboration between security staff and mental health staff. For example, when a prisoner breaks a rule or gets into an altercation in response to command hallucinations, he likely needs a more thorough psychiatric evaluation and more intensive mental health treatment, rather than a longer sentence to isolation and idleness.

I have found that the following policies and practices result in the imposition of isolated confinement, often with excessively long terms, for many prisoners suffering from SMI:

- prisoners with SMI escape detection because of inadequate mental health assessment;
- inadequacies in the mental health treatment program increase the likelihood that prisoners suffering from SMI will be punished with isolated confinement;

[1] My recommendations as to SHU, Keeplock, PC and other forms of isolated confinement are set forth in Sect. IX, Recommendations.

- a shortage of beds at CNYPC, and restrictive admission criteria, preclude admission of many prisoners in need of psychiatric hospitalization;
- observation cells, as currently operated, are equivalent to isolated confinement, and do not provide adequate assessment and treatment;
- there are insufficient Intermediate Care Program (ICP) beds for the population in need;
- there is a lack of vocational, educational, and other rehabilitation programs, as well as substance abuse treatment programs, especially for prisoners in isolated confinement;
- prisoners with SMI as well as serious discipline problems are ejected, or excluded from treatment programs;
- the disciplinary process fails to take mental health issues into sufficient consideration;
- inadequacies in mental health treatment programs at medium security facilities mean that prisoners with SMI will be sent to maximum security facilities for needed treatment, where they are subject to harsher conditions (and disciplinary sanctions);
- prisoners with SMI, often because of their psychiatric symptoms, acquire more tickets in isolated confinement, and, as they cannot control their behavior well enough to receive time cuts, they accumulate ever longer terms in isolated confinement;
- because staff often decide prisoners are "bad" and not "mad," many prisoners with SMI in SHU are not diagnosed or are un-diagnosed; and
- a vicious cycle ensues wherein prisoners with SMI cycle repeatedly from isolated confinement to observation or CNYPC, and then back to isolated confinement, accumulating more tickets in the process.

My interviews with prisoners in NY DOCS entirely confirm this general understanding of what happens to prisoners prone to mental illness in isolated confinement. In prisoners with a history of or vulnerability to psychiatric breakdown, irrational thoughts and primitive, disorganized behaviors often emerge. Internal impulses linked with anger, fear and hopelessness grow to overwhelming proportions. Many, if not all of the prisoners discussed in this report, demonstrate these reactions. The suffering and decompensation (psychiatric breakdown) experienced in isolated confinement is common among, but not limited to, prisoners with Schizophrenia, Major Depression or Bipolar Disorder.

Suicide is a huge problem in isolated confinement – and despair, depression, and thoughts and plans of suicide are widespread among prisoners in NY DOCS SHUs. OMH statistics for 1998 through 2000 (Report of June 4, 2002) reflect that in 1998 there were 14 suicides statewide; five occurred in SHU and one in Keeplock. In the same time period 3% of prisoners were housed in SHU and 5% in Keeplock. Thus, 36% of all the successful suicides in the entire department occurred among the 3% of prisoners confined in SHU.

The subjective sense many prisoners shared with me is a loss of all hope of ever leaving SHU. This kind of hopelessness adds to the despair and depression and drives many prisoners with SMI in SHU to contemplate self-destruction, and then to act on their suicidal ideas. When prisoners sense that staff do not take their pain and despair seriously, but rather view them as "malingerers" or "problem prisoners" whose only mental illness is Antisocial Personality Disorder, they experience even more despair.

In terms of suicide prevention, crisis intervention and the use of observation cells, NY DOCS' very punitive approach to suicidal prisoners is much more harsh than the evolving standards in the field require (Hayes, NCCHC).

There are well established clinical guidelines for the assessment and treatment of individuals who have attempted suicide or seem intent on taking their own life. Little or none of this occurs in the observation cells I inspected, in the accounts of observation I heard during my interviews, or in the charts I reviewed of both current cases and successful suicides.

One finds among the cases of successful suicides prisoners who were not diagnosed adequately or were "un-diagnosed" while incarcerated in DOCS, and then eventually proceeded to kill themselves. Residents of SHU are vastly overrepresented among successful suicides, as are individuals who have a very long sentence to serve in SHU. Among successful suicides, there are individuals who were discontinued from the OMH caseload even though they continued to suffer from SMI. There are also individuals who accumulated a large number of tickets while confined in SHU, and many of those tickets may well have been driven by their mental illness. There are individuals who cycled (or "ping-ponged") between SHU and observation and CNYPC and back to SHU. Finally, there are individuals who had been in ICP and were discharged on account of unacceptable behaviors. In fact, a snapshot summary of the stories of prisoners who successfully committed suicide in NY DOCS between 1995 and 2004 would look very much like a snapshot of the 183 prisoners I interviewed and describe in this report.

The fact that the OMH program has received accreditation by the Joint Commission on the Accreditation of Healthcare Organizations (JCAHO) does not eliminate nor ameliorate the presence of very serious problems in the mental health care delivery system. The JCAHO process, by its nature, fails to take into account many of the problems at issue in this litigation.

CNYPC is accredited by JCAHO, and is a quality psychiatric hospital. Still, there are problems with inpatient psychiatric service programs at CNYPC. The admission criteria for CNYPC are too stringent in that it serves as the only psychiatric inpatient facility for DOCS. Another problem is the severe shortage of beds at CNYPC. There are also too few aftercare options for patients being discharged from CNYPC. The most obvious reflection of this problem in NY DOCS is that prisoners who need intensive services remain in observation cells too long in the Satellite Mental Health Units or are returned to isolated confinement cells instead of being sent to CNYPC. I discovered many prisoners in observation who warrant immediate admission to an inpatient psychiatric unit, but languish in observation. In observation cells located in the prisons, treatment is entirely inadequate for the severity of the prisoners' psychiatric condition. The conditions of confinement are harsh and punitive – in contrast to the much more humane and therapeutic conditions at CNYPC.

In this report I outline many other deficiencies I discovered in the mental health treatment program in DOCS, including deficiencies in the screening and diagnostic process, a lack of adequate confidentiality, inadequate record-keeping (clinical charts), inadequate prescribing practices, too little non-medication treatment intervention with prisoners suffering from SMI, inadequate substance abuse programming for prisoners suffering from Dual Diagnosis (co-occurring mental illness and substance abuse), damaging use of force with prisoners suffering from SMI, and inadequate post-release planning.

According to the Corrections Yearbook 2001, between 1994 and 2001, the average percentage of prisoners in segregation and protective custody nationwide increased from 4.5% to 6.5%.[2] According to a Human Rights Watch report, New York's reported 7.8% of prisoners in segregation (SHU and Keeplock) is well above the average for the 36 states reporting on the number of prisoners in segregation.[3]

Litigation has led to the exclusion of prisoners with serious mental illness from longterm isolated confinement in California, Wisconsin, Texas, Connecticut, New Mexico and Ohio. Illinois DOC, by policy, excludes prisoners with SMI from the isolated confinement unit, Tamms. Even states that do not exclude prisoners with SMI from isolated confinement report, on average, that approximately 12% of the prisoners in isolated confinement suffer from SMI. NY DOCS and OMH report that the proportion of prisoners in SHU and Keeplock suffering from SMI is far above that national average, with as many as 64% of prisoners in SHU on the OMH caseload.

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[2] Camp, C.G., & Camp, G.N., Corrections Yearbook 2001: Adult Systems, Connecticut, Criminal Justice Institute, 2002, p. 38.

[3] Human Rights Watch, Illl-Equipped: U.S. Prisons and Offenders with Mental Illness, New York: Human Rights Watch, 2003.

I. Qualifications and Experience

My name is Terry A. Kupers, M.D., M.S.P. (See curriculum vitae, including forensic cases of past four years, Appendix A). I am Institute Professor in the Graduate School of Psychology of the Wright Institute in Berkeley and maintain a clinical practice in Oakland, California. I am a Diplomate of the American Board of Psychiatry & Neurology (Psychiatry, 1974, for life). I have served as President of the East Bay Psychiatric Association (local branch of the American Psychiatric Association); I am a Distinguished Fellow of the American Psychiatric Association; I served for several years as Co-Chair of the Committee on the Persons with Mental Illness Behind Bars of the American Association of Community Psychiatrists; I am a Fellow of the American Psychiatric Association and I am a member of the American Academy of Psychiatry and Law. I am on the staff of the Alta Bates Medical Center in Berkeley, and serve as consultant to several public mental health agencies. I recently served for two years as consultant to Connections, a collaboration between the San Francisco Sheriff's Department, Jail Psychiatric Services, the San Francisco Court's Jail Diversion Program and several community health agencies.

I received a B.A. in Psychology from Stanford University in 1964, with Distinction; an M.D. from UCLA School of Medicine in 1968 where I was elected to Alpha Omega Alpha Honor Society; I have been licensed to practice medicine in the State of California since 1968; I completed Internship at Kings County Hospital/ Downstate Medical Center in Brooklyn in 1969; I completed residency training in Psychiatry at UCLA Neuropsychiatric Institute (NPI), with a year elective at Tavistock Institute in London, in 1972; I did a fellowship in Social and Community Psychiatry (including Forensic Psychiatry) at UCLA NPI from 1972 to 1974; and I received a Masters Degree in Social Psychiatry (M.S.P.) from UCLA at the conclusion of that fellowship. Between 1974 and 1977, I was Assistant Professor in the Department of Psychiatry and Co-Director of the Psychiatry Residency Training Program of the Charles Drew Postgraduate Medical School in Los Angeles, and I was a staff psychiatrist and Co-Director of the Outpatient Clinic at Martin Luther King, Jr. Hospital. From 1977 to 1981, I was staff psychiatrist and Co-Director of the Partial Hospital Program at the Richmond (California) Community Mental Health Center (Contra Costa County Mental Health Services). I have conducted a private practice of psychiatry since 1974, and have been on the faculty of the Wright Institute since 1981. I received a 2005 Exemplary Psychiatrist Award from the National Alliance for the Mentally Ill at the annual meeting of the American Psychiatric Association on May 23, 2005.

I have written four books: Prison Madness: The Mental Health Crisis Behind Bars and What We Must Do About It (Jossey-Bass/Wiley, 1999); Ending Therapy: The Meaning of Termination (New York University Press, 1988); Revisioning Men's Lives: Gender, Intimacy and Power (Guilford Press, 1993); and Public Therapy: The Practice of

Psychotherapy in the Public Mental Health Clinic (Free Press, 1981). I am a co-editor of and contributor to Prison Masculinities (Temple University Press, 2001). I have written over two dozen articles, including "Malingering in Correctional Settings," (Correctional Mental Health Report, 5, 6, 81-, March/April, 2004), "Toxic Masculinity as a Barrier to Mental Health Treatment in Prison" (Journal of Clinical Psychology, Vol. 61, 6, 2005), "The Mental Health Crisis Behind Bars," (Harvard Mental Health Letter, July, 2000), "The SHU Syndrome and Community Mental Health" (The Community Psychiatrist, Summer, 1998), "Trauma and Its Sequelae in Male Prisoners" (American Journal of Orthopsychiatry, 66,2,1996, pp. 189-196), Jail and Prison Rape, (TIE-Lines, February, 1995), and "Contact Between the Bars: A Rationale for Consultation in Prisons" (Urban Health, Vol. 5, No. 1, February, 1976). Among book chapters I have written are "Psychotherapy with Men in Prison" (in A New Handbook of Counseling & Psychotherapy Approaches for Men, eds. Gary Brooks and Glenn Good, Jossey-Bass/Wiley, 2001), "Posttraumatic Stress Disorder (PTSD) in Prisoners," (in Managing Special Populations in Jails and Prisons, ed. Stan Stojkovic, Civic Research Institute, Kingston, NJ, 2005), "Schizophrenia, its Treatment and Prison Adjustment" (in Managing Special Populations in Jails and Prisons, ed. Stan Stojkovic, Civic Research Institute, Kingston, NJ, 2005). I wrote a Foreword for David Jones (Editor), Working with Dangerous People: The Psychotherapy of Violence (Oxon, UK: Radcliffe Medical Press Ltd., 2004).

I am Contributing Editor of Correctional Mental Health Report, and I am on the Editorial Advisory Board of The Juvenile Correctional Mental Health Report and three other professional journals. I was invited to give a keynote address at the International Association of Forensic Psychotherapists in Dublin, Ireland on May 20, 2005; and I have been invited to give a lecture at the 2005 Institute on Psychiatric Services of the American Psychiatric Association in San Diego, October 7, 2005, on "Prisoners with Mental Illness: Their Plight, Treatment, and Prognosis."

I have testified in over twenty criminal and civil proceedings, including state and federal courts, regarding jail and prison conditions, their effects on prisoners, and the quality of mental health services (see Appendix A and Appendix B for case citations). Cases concerning jails include Rutherford v. Pitchess (1977); Hudler v. Duffie (1979); and Branson v. Winter (1981). Cases concerning prisons include Toussaint/ Wright/ Thompson v. Enomoto, 1983 (regarding conditions of confinement and effects of double-celling in the Security Housing Units of the California Department of Corrections); Gates v. Deukmejian, 1989 (regarding the availability and quality of mental health services at the California Medical Facility in Vacaville); Coleman v. Wilson, 1993 (about conditions of confinement and the quality of mental health treatment for prisoners with mental illness in the California Department of Corrections); Cain v. Michigan Dept. of Corrections, 1998 (about conditions of confinement and their effect on mental health); Bazetta v. McGinnis, 2000 (about the effect of visitation and its restriction on Michigan prisoners); Jones 'El v. Gerald Berge, 2001 and 2002 (about the effects of isolated confinement on prisoners suffering from serious mental illness); and Willie Russell v.

Mississippi Department of Corrections, 2003 (about the conditions of confinement on Death Row at Parchman and the treatment of prisoners with serious mental illness).

I have served as a consultant regarding prison conditions and the quality of correctional mental health care to the U.S. Dept. of Justice, Civil Rights Division, and to Human Rights Watch and Amnesty International. I consulted to Human Rights Watch during their investigations and compilation of the report, Cold Storage: Super-Maximum Security Confinement In Indiana (1997). In 2002 I was asked by the Ohio Attorney General to serve as mental health monitor for the Austin et al. v. Wilkinson et al. litigation involving the exclusion of prisoners with serious mental illness from the isolated confinement unit at Ohio State Penitentiary, but I declined because of time constraints. I have participated in successful settlement negotiations in New Mexico (Ayers, et al. v. Perry, et al., No. CIV 02-1438 BB/WWD, 2003) and Connecticut (Office of Protection and Advocacy v. Choinski, et al., NO. CIV 3:03CV1352 RNC, 2004), both cases involving the removal of prisoners with serious mental illness from isolated confinement and the improvement of correctional mental health services. I have conducted trainings for correctional and mental health staff in departments of corrections, including NY DOCS and OMH ("The Role of Trauma in the Lives of Incarcerated Men and Women," Central New York Psychiatric Center, August, 1999).

I have been retained by Plaintiff and its counsel, and my rate of compensation is $150/hour for all work except Deposition and Testimony at Trial; for Deposition and Testimony at trial, my rate is $300/hour.

II. Questions Posed

I have been asked by counsel to consider five questions as I prepare this report, subject to my own emendations or revisions and any additional questions that may arise. The five questions are as follows:

- Why are there so many prisoners suffering from serious mental illness (SMI) in SHU and other locations of isolated confinement within the NY DOCS? (See Section IV.)
- What are the effects of isolated confinement on prisoners suffering from SMI? (See Section V.)
- Is the mental health treatment provided to prisoners with serious mental illness throughout the system adequate, and if not, do the deficiencies place large numbers of prisoners with serious mental illness at risk of psychiatric harm? (See Section VI.)
- How do New York's prisons compare with national trends? (See Section VII.)
- What recommendations can I make to improve the situation? (See Section IX.)

III. Preparation

A. Prison Tours and Interviews

I inspected 13 prisons and interviewed 183 prisoners as follows:

- Elmira Correctional Facility on 3/11/03 and interviews with 9 prisoners;
- Southport Correctional Facility on 3/12/03 and interviews with 6 prisoners;
- Five Points Correctional Facility on 3/13/03 and interviews with 8 prisoners;
- Sullivan Correctional Facility on 5/5/03 and interviews with 10 prisoners;
- Bedford Hills Correctional Facility on 5/6/03 and interviews with 11 prisoners;
- Clinton Correctional Facility on 7/15 and 7/16/03 and interviews with 21 prisoners;
- Upstate Correctional Facility on 7/17 and 7/18/03 and interviews with 19 prisoners;
- Sing Sing Correctional Facility on 5/7 and 5/8/03 and interviews with 21 prisoners;
- Great Meadow Correctional Facility on 8/26 and 8/27/03 and interviews with 25 prisoners;
- Wende Correctional Facility on 9/22/03 and 9/25/03 and interviews with 19 prisoners;
- Attica Correctional Facility on 9/23/03 and interviews with 7 prisoners;
- Albion Correctional Facility on 9/24/03 and interviews with 9 prisoners; and
- Auburn Correctional Facility on 10/29 and 10/30/03 and interviews with 18 prisoners.

Nearly all the 183 prisoners I interviewed were on the OMH caseload.

At each facility, I inspected as many housing units as time would permit. I was able to observe the various types of housing units (cellblocks, cells, dormitories, drug treatment programs, libraries, recreation facilities, eating halls, vocational programs, and others), and I inspected the areas where prisoners with mental illness are housed, programmed and treated. I also inspected general population housing and program areas. In particular, at each facility (with the exception of Upstate and Southport) I inspected the OMH Satellite Mental Health Units (hereinafter referred to as "Satellite Units"), where mental health treatment services, observation cells, and dormitories are located; at Upstate and Southport (which do not have Satellite Units), I inspected the Mental Health Unit, including the areas utilized for mental health treatment. At each facility I inspected

the Special Housing Unit ("SHU"). I also inspected the Intermediate Care Program ("ICP")[4] or AVP; the Special Needs Unit ("SNU") at Sullivan and Wende; the APPU and Meryl Cooper Unit at Clinton.

At every facility I inspected, I observed the physical plant and ongoing activities, asked staff and those prisoners I interviewed about the programs, asked prisoners about their psychiatric histories and current experiences, and performed mental status examinations of the prisoners. In a few cases, I discussed the clinical situation of prisoners with mental health staff, with the consent of the prisoner (and defendants) to do so. During these inspections, to the limited extent permitted by defendants, I spoke with superintendents, assistant superintendents and security officers; and to the limited extent permitted by defendants I spoke with representatives of OMH who accompanied me on tours, including Harold ("Hal") Smith, Dr. Donald Sawyer, Peter Russell, Dr. Algimantas Shimkunas, Dr. Anthony DeVito, and other staff and managers.

B. Review of Documents

I reviewed a large volume of documents, including DOCS and OMH operational policies, studies conducted by OMH of various components of its programming, and internal agency documents produced in this litigation. Among these documents are the ICP Manual, CNYPC Outpatient Medical Records Policy & Procedures Manual, CNYPC Outpatient Program Guide for 1995, OMH Study Mid-Late 80's, 1997 OMH Task Force Report, 2000 Corr. Assoc. Health Care Report, 6/12/00 MH Services Plan for SHU at Attica, 6/12/00 Plaintiff's Declaration Re: MH Services Plan for SHU at Attica, 11/00 Commissioner's Policy Paper on Prison Safety & Inmate Programming, 12/4/00 Testimony by Sarah Kerr to NYS Democratic Task Force on CJ Reform, 12/11/00 letter re: Double Occupancy Housing Units, 1/17/01 Double Occupancy Housing Units, Feb., 2000 and June, 2002 Reports by the Prison Visiting Committee. I reviewed reports and accompanying correspondence by the State Commission of Correction for 41 successful suicides that occurred in the NY DOCS or OMH between 1996 and 2003. I reviewed clinical charts and custody files of almost all of the 183 prisoners I interviewed, approximately 60 cartons of files. I reviewed at least four additional cartons of clinical files of the prisoners who successfully committed suicide. I was provided transcripts of depositions in this matter of Maureen Adams, Dr. David Barry, Jeffrey Bea, Takarla Carroll, John Culkin, Dr. Anthony DeVito, Charles Gordon, Gary Greene, Charles Herrmann, Leslie Kellam, Nancy Key, Sharon Keyser, Loretta Klein, Ram Lall, Frederick Lamy, Dr. Mitchell Langbart, William Lape, Lucien Leclaire, Elaine Lord, Richard Miraglia, Adele Pace, Maria Rosado, Peter Russell, Dr. Don Sawyer, Donald Selsky, Dr. Aligmantas Shimkunas, Harold Smith, Jayne Van Bramer, Dr. Bruce Way, Larry Woodward and Dr. Lester Wright. I reviewed all of these transcripts, some in full and some in part.

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[4] This and other acronyms, psychiatric terms, and other unfamiliar words used herein are defined in the accompanying glossary, attached hereto as Appendix G.

I also reviewed Minutes of the CNYPC Ethics Committee from 1997 through April, 2004; the Final Report of a 2002 Technical Assistance Intervention Project at Bedford Hills Correctional Facility by Angela Browne; 7/29/02 Overview memo to the Operations Committee re Behavioral Management in the Outpatient Correctional Setting; OMH Annual Reports for 2000 and 2003; Anderson Training power point images, 4/21/04, and accompanying video presentation; training materials for suicide prevention; videos of several "take-downs"/security operations. I reviewed many internal memos of DOCS and OMH as well as many studies of CNYPC, Satellite Units, observation cells, suicide, outpatient services and STP. I reviewed proposals for the Behavioral Health Unit (BHU). I also reviewed several cartons of miscellaneous documents generated in this case. A full list of the documents I had available are attached to this report as Appendix C.

IV. The Path to Isolated Confinement for Prisoners with Mental Illness

A. A Significant Number of Prisoners with Serious Mental Illness are in Isolated Confinement

The most striking feature of mental health services in the New York prisons I toured is the large number of inmates suffering from serious and persistent mental illness (referred to henceforth as "serious mental illness" or "SMI") who are housed in some form of isolated confinement, where they are kept isolated from other prisoners and have minimal contact with staff, spend nearly 24 hours per day in their cells, participate in very few if any programs, eat alone in their cells, and are mostly idle. Serious mental illness or SMI means a substantial disorder of thought or mood which significantly impairs judgment, behavior, capacity to recognize reality, or ability to cope with the ordinary demands of life.[5] New York's Mental Hygiene Law Section 1.03 (Definitions) 52 defines SMI as follows:

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[5] There are various definitions of serious mental illness. The 1986 federal Public Law 99-660 mandates that federally-funded public mental health programs prioritize services to individuals suffering from serious and persistent mental illness ("SPMI"), and this includes those who are disabled by a chronic mental illness, possibly exacerbated by co-occurring substance abuse or another condition such as AIDS. The federal government required the states to define SPMI for the purposes of their mental health plans. The courts have also proposed definitions; for example, the Michigan Department of Corrections, in USA v. Michigan (No. G84-63CA WD. Mich, 1996), adopted this definition of serious mental illness: "Serious Mental Illness means a substantial disorder of thought or mood which significantly impairs judgment, behavior, capacity to recognize reality, or ability to cope with the ordinary demands of life." The Madrid v. Gomez court (889 Supp. 1146, N.D. Calif., 1995) ordered that the California Department of Corrections be "permanently enjoined from confining in the Pelican Bay State Prison Security Housing Unit those 'at risk' inmates who meet one or more of the following definitions":

a. Inmates found to have current symptoms or who are currently receiving treatment for the following types of Diagnostic and Statistical Manual IV (DSM-IV) Axis I diagnosis:

(1) Schizophrenia (all sub-types)

(2) Delusional Disorder

> "Persons with serious mental illness" means individuals who meet criteria established by the commissioner of mental health, which shall include persons who are in psychiatric crisis, or persons who have a designated diagnosis of mental illness under the most recent edition of the Diagnostic and Statistical Manual of Mental Disorders and whose severity and duration of mental illness results in substantial functional disability. Persons with serious mental illness shall include children and adolescents with serious emotional disturbances.

Special Housing Units (SHUs) and Keeplock are both forms of punitive disciplinary confinement wherein the prisoner generally remains in his or her cell a minimum of 23 hours per day, with one hour allocated for recreation (23 hour

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(3) Schizophreniform Disorder

(4) Schizoaffective Disorder

(5) Brief Psychotic Disorder

(6) Substance-Induced Psychotic Disorder (excluding intoxication and withdrawal)

(7) Psychotic Disorder Not Otherwise Specified

(8) Major Depressive Disorders

(9) Bipolar Disorder I and II

b. Inmates diagnosed with a mental disorder that includes being actively suicidal.

c. Inmates diagnosed with a serious mental illness that is frequently characterized by breaks with reality, or perceptions of reality that leads the individual to significant functional impairment.

d. Inmates diagnosed with an organic brain syndrome that results in a significant functional impairment if not treated.

e. Inmates diagnosed with a severe personality disorder that is manifested by frequent episodes of psychosis or depression, and results in significant functional impairment.

f. Inmates diagnosed with mental retardation with significant functional impairment.

In correctional psychiatry, the designation "major mental illness" has traditionally been defined in relation to a number of "Axis I" diagnoses, including Schizophrenia, bipolar disorder, major depressive disorder, delusional disorder and so forth. The weakness of the last variety of definition is that there are many individuals who suffer from a mental illness that is not on the short list of diagnoses qualifying for major mental illness (for example, they suffer from Borderline Character Disorder or Posttraumatic Stress Disorder), but they are significantly disabled by mental illness. The definition I have adopted in this report, the Michigan definition, is consistent with the federal definition of SPMI, and is inclusive of the Madrid legal definition. From my review of documents in this case, it appears that OMH and DOCS do not consistently use any particular definition of serious mental illness. Thus, for example, Richard Miraglia, Director of the OMH Bureau of Forensic Services, testified that Serious Mental Illness, Serious and Persistent Mental Illness (SPMI), and Major Mental Illness are all used interchangeably, and they are defined as a "a psychotic disorder or major mood disorder" (Miraglia Deposition, pp. 151-157). In other words, for Mr. Miraglia, there is no distinction between SMI, SPMI and Major Mental Illness, and all of these terms refer to a few diagnostic categories without regard to functioning. Others in OMH define these terms differently.

confinement is also known as "lockdown"). In NY DOCS, SHUs are housing areas where all the prisoners in a given area are held in such 23 hour confinement.[6] Keeplock status prisoners may be held in lockdown confinement in a general population unit, a long-term Keeplock unit (where all prisoners are on Keeplock status), in general population, in an Intermediate Care Program (ICP), or in a SHU. There are also prisoners who are held in lockdown or isolated confinement conditions based on their status as Protective Custody or Administrative Segregation prisoners.

In some facilities, SHU cells measure 6x10 square feet, in some they are a little larger, and in some, for example at Sing Sing, SHU cells can be 6x8 square feet. The majority of prisoners in isolated confinement are housed in SHU cells. (As of December, 2001, there were 5,469 SHU cells system-wide, approximately 12% of DOCS total capacity at that time, 68,000 – see SHU Mental Health Needs Study by Dr. Bruce Way/CNYPC, 5/17/02).

In the course of inspecting 13 facilities and interviewing 183 prisoners, I interviewed well over 100 prisoners who were housed in SHU, Keeplock, or some other form of isolated confinement, and I concluded that more than 75% of prisoners I interviewed in isolated confinement settings suffered from serious mental illness or were at very high risk of suicide. Most of them are on the OMH caseload, are being seen briefly by OMH staff at cell-front with occasional private meetings, and are being prescribed psychiatric medications, but in almost every case they are undergoing very little or nothing else in the way of mental health treatment. Some prisoners with SMI have been placed in observation in the Satellite Unit or have been admitted to an inpatient psychiatric ward at CNYPC on one or more occasions, and then were returned to prison – often back to isolated confinement. Further, many prisoners suffering from serious mental illness repeatedly cycle between isolated confinement and observation and/or CNYPC and back to isolated confinement. CNYPC is an (JCAHO) accredited psychiatric hospital, and the treatment prisoners receive there is very different than what happens in the prisons. But the observation cells I toured in the Satellite Units are similar to isolated confinement cells. There are more frequent rounds by correctional and nursing staff – the prisoners who are in observation are watched more closely than in SHU or Keeplock. These patients in observation see the psychiatrist, usually as he or she passes briefly by the front of the observation cell. But often the prisoners in observation have fewer amenities than they did in their isolated confinement cells, limited to a smock (Ferguson non-destructible gown) and a thin mat. Inmates in observation usually do not get to go out of their cell for recreation, even for the one hour that is generally available to SHU and Keeplock prisoners[7].

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[6] The only very limited exception are prisoners in the Special Treatment Program ("STP"), which will be discussed subsequently.

[7] Indeed that one hour of recreation often does not take place, given the many times when a prisoner with SMI is unable to respond immediately to the officers' call out.

As I will explain below, it is my strong professional opinion that prisoners with serious mental illness should not be housed in isolated confinement (SHU, Keeplock, Administrative Segregation, or Protective Custody when it involves lockdown)[8], and that the isolation and idleness of observation should be ameliorated, because:

- isolated confinement tends to worsen the prisoner's mental illness and prognosis, causing unnecessary suffering;
- prisoners' mental impairments prevent them from remaining free of disciplinary infractions long enough for them to gain release from isolation; and
- prisoners with SMI need more intensive ongoing mental health treatment and programming than is available in isolated confinement settings.

Many prisoners I met have not been evaluated adequately by the mental health staff. Others are considered by OMH staff to be "malingering" or to have "merely an Axis II personality disorder" with no bona fide mental illness, and in other cases the OMH staff believe that a prisoner's psychotic disorder or severe mood disorder is controlled sufficiently by psychiatric medications that the prisoner is "functional" or "stable" in an isolated confinement setting. But while a prisoner who is actively hallucinating or actively contemplating suicide in his isolation cell may appear to a casual observer hurriedly passing by his cell to be relatively "functional" – perhaps he dresses himself, eats his meals and does not cause a commotion – he can still be suffering tremendously on account of his serious mental illness and the conditions of his confinement. I will discuss the conditions of confinement and lack of programming in observation later in this report. For now, I should merely note that **the prisoners in observation with whom I spoke consider observation to be an even more noxious setting then their isolated confinement cells.**

In this section, I will focus on prisoners in isolated confinement (as defined above). Consider this illustrative case (for this and all other cases summarized in the text of this report, see Case Studies, Appendix D, for a more complete picture):

> N.D. **(Interviewed while housed in SHU at Southport, 3/12/03).**
>
> <u>History:</u> This man has been in prison for eight years, and has been in SHU for seven of those years at various institutions. He said he has taken psychiatric medications "for the voices," but has been off his medications since coming to Southport one year earlier – he discontinued them because

[8] My recommendations as to SHU, Keeplock, Protective Custody and other forms of isolated confinement are set forth in Section IX, Recommendations.

they made him too sleepy and caused weight gain. Then he was dropped from the OMH treatment list. He was actively hearing "voices," he was depressed and for significant periods he would not eat. He has attempted suicide on multiple occasions. He received many tickets when he was in "The Box" (SHU), for example for flooding his cell or setting fires; he explained he does these things because, "In the Box the voices become stronger, I get depressed, it feels like the walls are closing in on me, and I just want to die." In the past, he has been prescribed the anti-psychotic agents Haldol and Zyprexa, as well as mood stabilizers, and the medications had good effects on his mental condition. His history of serious mental illness long pre-dates his incarceration. He says that a big part of his reason for not taking medications is that the officers call prisoners who take psychiatric medications "bugs."

Mental status examination: This prisoner had flat affect, stared in bizarre fashion and had obvious internal preoccupations, indicative of auditory hallucinations. He seemed depressed but was not currently suicidal. When I asked him why he had momentarily broken off communication with me and seemed preoccupied, he averred hearing voices. In other words, this man's presentation is consistent with active psychosis and depression.

Clinical chart: N.D. chart is consistent with the history he presents. He was admitted from SHU to CNYPC on 4/1/99 and his diagnosis was downgraded to Adjustment Disorder with mixed features, but his discharge medications, as he returned to SHU, were Depakene 750 mg. b.i.d. (a mood stabilizer prescribed to patients suffering from Bipolar Disorder) and Zyprexa 10 mg. (an anti-psychotic medication). A Nursing Assessment on 1/23/01 stated he was admitted to observation for "danger to self and others," after he ingested pills and reported it was because "the voices keep screaming at me" and "the voices tell me what to do." He was noted to have "disintegration of thought process as evidenced by impaired insight and judgment and auditory hallucinations." There were multiple transfers to observation for serious suicide attempts, each followed by a return to SHU. Strong psychiatric medications were prescribed. Mental status on a 11/21/01 Core Evaluation included: "Unshaven, unkempt, preoccupied with 'voices,' claims he hears voices telling him 'kill himself', depressed, agitated, attempted OD (overdose) in SHU, oriented X3, somewhat confused."

This case illustrates several themes I will discuss in more detail below:

- This prisoner was suffering from a serious mental illness and has been known to suffer from a serious mental illness since childhood;

- he had been confined to SHU for at least a year;
- he was not functional in SHU as demonstrated by his repeated suicide attempts and psychotic breakdowns necessitating transfer to observation and, in one instance, the psychiatric hospital;
- his mental illness was almost certainly exacerbated by isolated confinement, but then OMH staff repeatedly "re-cycled" him back to SHU, notwithstanding his severe symptoms and continuing danger to self;
- his diagnosis was changed from serious mental illness (psychosis NOS and Major Depressive Disorder) to the less serious diagnosis "Adjustment Disorder" (this downgrading is the phenomenon I term "un-diagnosis");
- he was continued on psychiatric medications that are indicated for psychosis and severe mood disorders and not for Adjustment Disorder;
- he was eventually dropped from the OMH caseload because he refused to comply with medications in spite of continuing hallucinations and other signs of psychosis and depression;
- his continuing signs of serious mental illness were not detected at periodic mental health screening evaluations done without privacy at cell-front;
- he was assigned a lower mental health needs level and transferred to a facility (Southport) that was inappropriate for his level of psychiatric disorder.[9]

Unfortunately, N.D. case is neither isolated nor rare. Of the 183 prisoners I interviewed during my visits to 13 DOCS facilities between March 11, 2003, and October 30, 2003 (including prisoners I interviewed in observation and elsewhere), more than 150 had spent significant periods in SHU and over 140 suffered from serious mental illness. Many of the themes I listed in relation to this prisoner are widespread among the prisoners I interviewed.

There are many reasons why prisoners suffering from SMI end up in disciplinary isolation in disproportionate numbers, some having to do with the nature of mental illness and institutional dynamics, and others that result from ill-advised and harmful policies and practices within DOCS and OMH.

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[9] OMH has designated mental health levels of need ranging from 1 to 4 in descending levels of need for services; level 1 signifies a need for the most intensive services, level 6 signifies no need for services (there is no level 5). The "mental health level" assigned to a prisoner reflects that such prisoner must be housed in a prison that has adequate mental health treatment capabilities. Thus prisoners with mental health level 1 must be housed in a prison with a Satellite Unit, and/or officially precluded from confinement at Southport which does not have a Satellite Unit. Prisoners with Mental Health Level 1 or 2 are precluded from confinement at Upstate.

B. Institutional Dynamics and Rules Place Prisoners with Serious Mental Illness at Risk

Mental illness and the institutional dynamics of a correctional setting do not mix well. Prisoners suffering from serious mental illness are especially vulnerable to problems arising out of prison life. They are prone to victimization by other prisoners, are disproportionately victims of rape, and tend to break rules, get into fights, and get into disciplinary trouble. These tendencies have much to do with their mental illness. For example, individuals suffering from Schizophrenia and other chronic mental illnesses, on average, are not very alert to social cues and are not as capable as others of conforming their behavior to social expectations. This is true in the homes and neighborhoods where they grew up, but even more true in prison, where the rules are more stringent and more rigorously enforced. The nuances of prison rules and expected behaviors escape them. For example, most prisoners learn that there are many more rules than the staff could possibly enforce, and as long as they follow the rules staff seem to be enforcing they can get away with breaking the ones staff less diligently pursue. In contrast, prisoners with serious mental illness are often unable to make this distinction. Often they are written up for breaking rules that other prisoners know they must follow. It can be a simple thing such as failing to clean themselves or their cell or failing to stand for a count.[10] However even these simple rules can pose a problem for prisoners who suffer from serious mental illness and/or experience side effects of their strong psychotropic medications.

Some prisoners suffering from SMI get into disciplinary trouble because other prisoners take advantage of them and "sucker" them into stealing or holding contraband, and then leave them to take the rap. Or, either as aggressor or as hapless victim, they get into physical altercations. A mood disorder such as Bipolar Disorder, especially during a manic mood swing, can be expressed in temper outbursts or uncontrollable rule-breaking behaviors that may lead to isolated confinement. The following two cases are illustrative.

N.P **(Interviewed while housed in General Population at Great Meadow on 8/26/03.)**

History: This man has been in prison since his teens. He was taken to observation after trying to hang himself and cut his wrist. He had been in ICP prior to that. He was taking Depacote (mood-stabilizer typically

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[10] A comparable example from the community involves homeless people sleeping illegally in a public park. Typically in the community, the police might perform a sweep through the park in the middle of the night once every couple of weeks. Most of the homeless people sleeping there see the approaching lights of the police vehicles, pick up their sleeping bags and possessions, and leave before the police can roust them. But homeless people suffering from mental illness - either because their medications prevent them from waking when the lights come near, or because they do not think of getting up and leaving – are the only ones left for the police to arrest. And too often they get into squabbles with the police, and arrests follow. Equivalent scenarios occur in prison, resulting in a disproportionate number of tickets for prisoners suffering from serious mental illness.

prescribed for Bipolar Disorder), Zyprexa (anti-psychotic), Paxil (antidepressant) and Vistaril (anti-anxiety). He was in SHU from Dec., 2001 through April, 2002. He told me: "When I was in the Box the demons came through the walls – the wall of fire – and then the voices came and tormented me – then I cut my right cheek with a staple – then I wrapped myself in a sheet and set myself on fire." He went to observation for several months beginning in August, 2002. He was in the dorm and then he was sent to ICP. He was expelled from ICP in June because he had tickets. He was placed in general population (GP), where he has a lot of trouble - he gets picked on and threatened and just doesn't know what to do. He described his experience in observation as painful and humiliating because he was stripped and left without clothes for long periods.

Mental status examination: This man stared bizarrely, was internally preoccupied (consistent with reported hallucinations) and seemed frightened, especially about being returned to GP. His memory was very deficient. He is distrustful of mental health staff and explained that that is why he refuses to tell them about his fears.

Clinical chart: There were notes in his clinical chart about anxiety, paranoia, and one diagnosis of PTSD, another of Paranoid Schizophrenia (12/26/2000). He was discharged from the Auburn Satellite Unit on 10/16/01 after a three-month stay, with a note that his paranoia was diminished. While in ICP, he was prescribed Depacote, Zyprexa, Paxil and Vistaril on 5/6/03. Subsequently it was noted he has been kicked out of ICP for non-compliance with rules. There was a note about his being attacked while in GP, and that he had a cut on his face.

This man suffers from SMI, is victimized and does not know how to behave in GP. He needs to be in a relatively safe and therapeutic setting such as ICP, but he is kicked out of ICP for not following rules. His illness was already severely worsened in general population at the time of our interview. In essence, OMH and DOCS bar necessary treatment for prisoners who commit infractions that are driven by the very mental health conditions ICP is designed to treat.

J.Z. **(Interviewed while assigned to SHU and in observation at Bedford Hills on 5/6/03).**

History: J.Z. was handcuffed and wore only a Ferguson gown during my interview. She claimed she is denied food in observation, is denied a shower, and that the officers harass and threaten her. She has been staying up all night, talking to herself in observation (generally this can be a sign of mania). She had been in observation for 15 days. Last year she was in observation for 34 straight days. She has been in SHU for a year. Being in SHU causes her mental illness to be worse. She has severe insomnia in

SHU and is unable to concentrate or read, and becomes very agitated because of the constant screaming and noise, and harassment by staff (her story is consistent with an episode of mania exacerbated by SHU confinement). She has smeared feces on the wall, something that she was ashamed of and never did previously. She has made multiple suicide attempts. In observation she was never taken out of her cell to talk to anyone. Most of the behaviors that resulted in tickets and an even longer SHU term occurred when she was in a manic state, and often when she was in SHU. Her mental illness makes it impossible for her to control her temper.

Mental status examination: She exhibited pressured speech, flight of ideas, agitation and anger. She was not actively hallucinating, nor was she delusional. She credibly described cycles of mood consistent with Bipolar Disorder. She was not psychotic at the time of our meeting, but she presented a credible history of transient psychosis during angry or manic periods. She was intelligent, had a significant amount of insight, and was angry about the way she was being treated.

Clinical chart: The chart contained many notes about manic mood and pressured speech, diagnoses of Bipolar Disorder, mania and Delusional Disorder, and she has been prescribed mood stabilizing medications as well as antipsychotic medications. Despite these medications her symptoms worsened in SHU. She was admitted to CNYPC for the third time on 7/10/03 (two months after our interview). She had many admissions to observations from SHU, with discharge back to SHU.

This prisoner quite clearly suffers from severe mood swings consistent with a diagnosis of Bipolar Disorder, and it is likely that the manic behaviors she described and the manic state I observed during our interview play a large part in her being given tickets and repeatedly being sentenced to SHU terms – i.e. her mental illness causes her to be incapable of controlling her inappropriate outbursts. She seemed during our interview to be in an acute manic state, and the appropriate treatment would be admission to a psychiatric hospital. Yet she was kept naked (except a gown) and idle in an observation cell for weeks at a time, she was handled harshly, and she received very little in the way of mental health treatment.

C. Prisoners with Serious Mental Illness Also Have Difficulty with Unwritten Rules

There are also unwritten rules in prison, and prisoners with serious mental illness have difficulty understanding and conforming to this second set of rules. An example is the unwritten "prison code" in men's institutions. Men are not supposed to show any sign of weakness and they are absolutely prohibited from "snitching" to staff. A prisoner who suffers from SMI is labeled a weakling because of scars on his wrist from previous

suicide attempts; he may be more prone to attack because he is considered unlikely to have friends who would retaliate. If he is seen talking too long to an officer, he may unwittingly be labeled a "snitch." Even if the prisoner suffering from SMI was not "savvy" and was not the instigator, he is more likely than others to receive a ticket when altercations occur. The staff's impatience with prisoners whose mental illness leads them to do strange and disruptive things may result in these prisoners being placed in isolated confinement as well. In the NY DOCS, prisoners with serious mental illness account for a disproportionate number of disciplinary tickets that lead to SHU confinement.

Of course, prisoners suffering from serious mental illness also misbehave willfully – I am not advocating excusing their willful unacceptable behaviors, nor am I suggesting that there should be no consequences for their deliberate rule-breaking or assaultiveness. There have to be fair consequences for misbehavior and violence. But here I am attempting to explain why an inordinate number of prisoners suffering from serious mental illness run afoul of that disciplinary system and land in isolated confinement. **For prisoners with SMI, the consequences for unacceptable behaviors must be determined in the context of mental health assessment, diagnosis and treatment, and this requires a high level of collaboration between security staff and mental health staff. For example, when a prisoner breaks a rule or gets into an altercation in response to command hallucinations, he likely needs a more thorough psychiatric examination and more intensive mental health treatment rather than a longer sentence to isolation and idleness.** The vulnerabilities I am describing make it essential that prisoners suffering from serious mental illness be provided a relatively safe and therapeutic setting to serve their prison term. Absent that kind of setting, it is predictable they will decompensate, get into disciplinary trouble, and be sent to punitive isolated confinement. I will briefly describe another prisoner I interviewed.

A.M. **(Interviewed while in SHU at Five Points on 3/13/03).**

History: This man has been in SHU for ten years, and told me he has received 100 tickets, mostly while in SHU. He has been in observation approximately 30 times, at CNYPC a number of times and has been in ICP several times. He was in STP for three months, and when asked why his stay was terminated he said with a bizarre grin, "I'm too wise for it." He hears voices. He told me that other prisoners are always knocking on the walls around him. He has terrifying dreams. He talks to himself. He believes the officers play tricks on him, and poison his food. He told me the voices tell him to do things that get him into trouble, or he gets so angry at the officers who are playing tricks on him that he "acts the fool." He is taking Depacote, Haldol and Zyprexa.

Mental status examination: This man appeared bizarre, looking around and making faces. His thought process was loose and tangential. He was

agitated and his affect was inappropriate at times. He was concrete. He said he was hearing voices, and did seem internally preoccupied. He had clear ideas of reference (paranoid delusions). He said he has psychic powers. He was obviously trying to concentrate and cooperate with the interview, but he was confused and unable to track the conversation. He went off on tangents repeatedly, but was cooperative when the interviewer gently tried to lead him back on subject. His presentation is consistent with acute psychosis, and the presence of fixed delusions, that took years to form, point to chronic psychosis as well.

Clinical chart: A.M. chart is consistent with the picture he presents. He has been repeatedly admitted to observation for self-harm, burning his cell, etc. He has been prescribed Haldol decanoate (injection, an older anti-psychotic medication) 100 mg. every three weeks. He was also prescribed Depakene 1500 mg. (a mood-stabilizer prescribed for Bipolar Disorder and other Mood Disorders), Zyprexa 5 mg. (a newer, "atypical" anti-psychotic medication) and Cogentin. He had been in SHU a long time, and went to STP in Jan., 2002, at Five Points. He had multiple admissions from SHU to CNYPC and observation, and then cycled back to SHU each time.

This case serves to illustrate the problem (among others) that confining individuals with SMI in SHU (or Keeplock or other forms of isolated confinement) often leads to deterioration in their condition and more tickets (and more serious ones) because of the conditions of isolation and idleness. OMH inappropriately relies primarily on medications to treat psychiatric symptoms, without removing them from the noxious conditions and without supplying the other treatment modalities that are indicated. I have already observed a similar pattern in the cases of N.D., N.P. and J.Z.. See also the cases of W.Y., N.A., V.M., E.E.M., D.R., B.B.I., T.R., M.N., D.D.X., L.A., Q.I., O.P., B.Q., I.V., Q.H., P.J., R.X., Z.H., T.J., and I.D. in this Report; and the cases of O.N., O.E., F.O., T.H., C.C.T., X.F., W.C., R.P., J.A., E.Z., U.M., J.U., E.E.N., Z.J., I.T., S.J., C.E., P.T., in Case Studies, Appendix D.

D. Harmful Policies and Practices Lead to Prisoners with Serious Mental Illness Being Placed in Isolated Confinement

The most obvious reason why so many prisoners suffering from serious mental illness are relegated to isolated confinement is that NY DOCS and OMH permit them to be there. This trend is reflected in OMH studies and in statistics about suicides within DOCS. Thus, 64% of prisoners in SHU in OMH Mental Health Level One correctional

facilities are on the OMH caseload,[11] and as many as 45% of successful suicides within DOCS involve prisoners assigned to isolated confinement, even though only approximately 8% of DOCS prisoners are housed in isolated confinement at any time. [12] The September 4, 2003, Minutes of the NYS Commission of Correction Medical Review Board, summarizing a presentation to the Board by Richard Miraglia, Dr. Donald Sawyer and Harold Smith, go so far as to designate the housing of prisoners with serious mental illness in SHU as a method for managing them: "[An] intensive case management model is underway. This will provide special intensive case management for some 550 Level I seriously mentally ill state prison clients who are refractory to traditional treatment and are managed primarily in SHU's."[13] (See Pl. Exh. 574.) Thus, by design [or default], Special Housing Units are utilized to manage prisoners suffering from serious mental illness.

Many states have enacted policies that preclude isolated confinement for prisoners suffering from serious mental illness, reflecting a growing consensus among mental health professionals that isolated confinement can be very harmful to prisoners suffering from SMI. Several mental health professionals in OMH agree with that consensus, according to statements made in depositions or documents by Drs. Sawyer, Shimkunas, DeVito and Tucker. [14] Nevertheless, New York DOCS and OMH have continued to consign a large number of prisoners suffering from serious mental illness to its SHUs, to Keeplock status and other forms of isolated confinement, and to extended time in harsh observation cells in Satellite Units.[15]

The following policies and practices result in the imposition of isolated confinement for many prisoners suffering from SMI:

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[11] Kahjekian and Way, "Special Housing Units in OMH Level 1 Correctional Facilities: Mental Health Needs Study," 7/16/04.

[12] See The Correctional Association of New York, "Mental Health in the House of Corrections," 2004, p 57; NY DOCS "Inmate Suicide Report: 1995-2001" & "Inmate Suicides: 2002-April 17, 2004. " Plaintiff's counsel in this case prepared a chart of suicides between 1995 and mid-2004, which demonstrates that in those years 53 of the 119 known suicides, or 45%, involved prisoners assigned to some form of isolated confinement (See Appendix D). NY DOCS reports the figure of 34%. I have reviewed counsel's list of actual cases, and I find the 45% figure to be more accurate.

[13] Hal Smith disavows the claim that OMH is actually embarking on intensive case management with prisoners in SHU who have SMI (4/29/05 Deposition, pp. 336-338).

[14] See my discussion in Section VI.I.3, below.

[15] There are aspects of the isolation and idleness in Keeplock and observation that lead to even worse duress and emotional damage than obtains in SHU. For example, in Keeplock there are no regular mental health rounds and periodic mental health evaluations are not required (see DeVito Deposition, p. 142); and the prisoners in observation, some of whom remain there for months, are often denied clothing and other amenities and are not permitted out-of-cell recreation – see discussion of observation in Section VII.

- Prisoners with serious mental illness escape detection because of inadequate mental health assessment.

- Inadequacies in the mental health treatment program increase the likelihood prisoners suffering from serious mental illness will be punished with isolated confinement.

- A shortage of beds at CNYPC, and restrictive admission criteria, preclude admission of many prisoners in need of psychiatric hospitalization.

- Observation cells, as currently operated, are equivalent to isolated confinement and do not provide adequate assessment and treatment.

- There are insufficient ICP beds for the population in need.

- There is an unavailability of vocational, educational and other rehabilitation programs, as well as substance abuse treatment programs, especially for prisoners in isolated confinement.

- Prisoners with serious mental illness as well as serious discipline problems are ejected from treatment programs.

- The disciplinary process fails to take mental health issues into sufficient consideration.

- Inadequacies in Mental Health Treatment Programs at medium security facilities mean that prisoners with serious mental illness will be sent to maximum security facilities for needed treatment, where they are subject to harsher conditions, which tend to exacerbate their mental illness, which leads to violations of rules and the implementation of disciplinary sanctions, often meaning more time in isolated confinement.

- Prisoners with serious mental illness decompensate in isolated confinement and acquire more tickets, which makes them ineligible for time-cuts, and they accumulate ever longer terms in isolated confinement.

- Prisoners with serious mental illness in SHU are not diagnosed or are un-diagnosed, and at some point staff decide they are "bad" and not "mad."

- A vicious cycle ensues where prisoners with serious mental illness cycle repeatedly from SHU or Keeplock to observation or CNYPC and then back to SHU or Keeplock, accumulating more tickets in the process.

I will briefly describe each of these policies and practices and provide illustrative cases.

1. Prisoners with serious mental illness escape detection because of inadequate mental health assessment.

I found problems with case-finding or screening and diagnosis at every stage of prisoners' progression through the DOCS system. Prisoners entering DOCS are screened for mental health issues at Reception, and approximately 40% are seen for a face-to-face clinical assessment.[16] But a certain number of prisoners with a history of serious mental illness will deny they have emotional problems when they are screened in Reception and will therefore avoid clinical evaluation by OMH. There are various reasons for this. Some are afraid of the stigma that goes along with a diagnosis of mental illness, and that stigma can be especially intense in prison, where scars from past suicide attempts give one a reputation as a "weakling" or a "bug," and can result in victimization. Other prisoners fear being medicated or hospitalized against their will. And still others are intent on killing themselves and do not want to tell staff because staff would try to stop them. After the prisoner leaves Reception, there are limited other opportunities for mental health staff to discover cases requiring mental health treatment. There are screening mental health assessments conducted when security staff report a potential problem, periodic mental health evaluations for prisoners confined in SHU, and so forth. However, I discovered flaws in the screening and diagnostic procedure at each step. The result is that many prisoners who are suffering from serious mental illness and require mental health services are not on the OMH caseload.

The fact that prisoners suffering from SMI escape detection can also have much to do with the life course of serious mental illness, which follows a waxing and waning course over a life-time. On average, a first breakdown will likely occur in the late teens or early 20's – i.e., at the beginning of adulthood. Between acute breakdowns, the individual might appear fairly sane and healthy, especially when younger and not yet scarred heavily by the traumas of chronic mental illness. People typically enter prison in their late teens or early twenties. Some will have already suffered from psychiatric breakdowns or will have attempted suicide, will have been admitted to a psychiatric hospital, will have been treated with psychiatric medications, or might even have been approved for Social Security Disability (SSI) on psychiatric grounds. But a significant number of young men and women enter prison without yet having suffered a psychotic or manic or depressive breakdown, and of these, the ones who are going to suffer from SMI will experience their first breakdown some time after entering prison. All of these possibilities have to be considered by clinicians if they are going to diagnose mental illness. The past history is important, and must be reviewed, as a prior episode of serious mental illness makes a recurrence more likely. But since some prisoners will experience their first breakdown behind bars, the clinician cannot rely solely on past history either, and must conduct a careful mental status examinations in a private setting.

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[16] Staffing Plan, Downstate Correctional Facility, August, 2001.

In my review, past clinical records were not reviewed or were not sufficiently considered by OMH clinicians. In other cases, an unremarkable current mental status examination was erroneously relied upon to downgrade a diagnosis or question a prisoner's credibility. And in far too many cases, a very superficial examination was performed, typically at cell-front. These evaluations fall far short of acceptable diagnostic practice, missing many obvious signs of serious mental illness. These prisoners are then deprived of necessary mental health treatment, since OMH claims such treatment is not indicated. Predictably, many of these prisoners decompensate and suffer immeasurably.

Stress worsens mental illness, and removing an individual from the stressful situation can result in fewer symptoms. Thus, when a prisoner hears voices or thinks seriously about suicide under the duress of isolation and idleness in SHU, and then he or she is transferred to CNYPC where there is more social contact, more meaningful activities and less stress, many of the symptoms might diminish in intensity or resolve. This does not mean he was "faking" the voices or suicidal plans he reported when he was experiencing the stress of isolated confinement.[17]

Many prisoners I interviewed are clearly suffering from serious mental illness but at some point in their tenure within DOCS they are "un-diagnosed." By this I mean that their diagnosis is changed from "Schizophrenia" or Major Depressive Disorder" or "Bipolar Disorder" on Axis I of the DSM IV[18] to "no Axis I Diagnosis," "malingering," or "Antisocial Personality Disorder (ASPD)" on Axis II, or to a less serious diagnosis such as "Adjustment Disorder" on Axis I. I employ the term "un-diagnosis" to mean that an individual's diagnosis is downgraded in this fashion, even though it is often my finding that he or she actually suffers from SMI. In some cases prisoners who are thus un-diagnosed are removed from the OMH caseload entirely.[19] Another reflection of a lack of concern about case-finding is the fact that required periodic mental health assessments in isolated confinement are usually performed at cell-front, where the prisoner is not likely to share with the clinician anything significant about his or her emotional condition. It is widely known that prisoners will not discuss private matters under these conditions for fear of being overheard, and that such perfunctory cell-front contacts do nothing to forge a therapeutic alliance. Here is an illustrative case:

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[17] Another danger of staff presuming a prisoner is faking is that prisoners who are trying to access OMH services decide it is futile because they will not be believed. Alternatively, prisoners may decide that the only way to access needed mental health services is to do something – anything – to get staff to notice them.

[18] Diagnostic and Statistical Manual of the American Psychiatric Association, 4th Edition, Washington, D.C.: APA, 1994.

[19] I will discuss this problem in greater detail, including the use of the Psychopathy Checklist in the process of un-diagnosing, in Section IV.

W.Y. **. (Interviewed while housed in Upstate SHU, 7/17/03).**

History: This man has been in DOCS since 1992, and told me he has been at Upstate since Christmas (2002). He is being seen by mental health staff and has spent much time in "the Box." He finished the eighth grade in Special Education, and has heard voices commanding him to do things for many years. He had at least two psychiatric hospitalizations, at Kings County Hospital and at Brookdale, prior to incarceration.

Mental status examination: W.Y. could not remember his birthdate, was confused and was disoriented as to place, time and person. He exhibited loose and tangential associations. He was clearly internally preoccupied with hallucinations, and was not coherent enough for me to determine whether his thinking was delusional. He told me he takes "a pint of Haldol a day" and yet still was hearing voices, even in his sleep.

Clinical chart: The chart was surprisingly thin. On 1/16/98 it was noted he was naked in the Attica SHU, but no mental health services were requested – the plan was to monitor him because of his appearance. An outpatient progress note of 10/13/98 at Attica reflects he was in the SHU, being evaluated by OMH because of inappropriate sexual acts including masturbating in front of staff, and he had no psychiatric history [sic]. On OMH Admission Services forms for 4/15/99, 10/23/02, 11/13/02, 1/3/03, and 3/3/03 there was no diagnosis, he was designated Mental Health Level 6 (eventually removed from the caseload), and the box was ticked for "no services indicated." A fuller clinical note on 10/23/02 reflected no evidence of mental illness. Elsewhere it was noted that he had been on SSI total disability on psychiatric grounds in the community, was in Special Education, and had an IQ of 81.

W.Y. bizarre behavior, noted as far back as January and October, 1998, raises a serious question whether he was acutely psychotic even then, but there was no real psychiatric treatment given. There is no thorough psychiatric evaluation in the chart, and the 90 day mental health screenings seem very superficial, as if a clinician passed by this prisoner's cell-front and checked off that there was no problem. Based on my assessment, W.Y. very likely suffers from an organic brain disorder and/or developmental disability as well as functional psychosis, and has been quietly psychotic in his cell for a long time. His case demonstrates, among other things, the dangers associated with failure to diagnose co-occurring disorders, such as organic brain disorder, in someone with functional psychosis that is co-occurring with low intellectual functioning or mental retardation. Had OMH staff engaged in more than brief cell-front encounters with W.Y., they would have noticed that something was very wrong. (Besides W.Y. see other cases in this Report that reflect this issue, including

D.R. , D.P. , D.D.X. ; M.N. and T.R. ; and many more cases in Appendix D, Case Studies). Here is another case, like that of W.Y. where SMI was not identified by OMH:

> C.C.O. **. (Interviewed while housed in Upstate SHU on 7/18/03).**
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> **History:** C.C.O. came to Upstate in May, 2003, from the SHU at Southport. He was prescribed Cogentin, Risperdal (anti-psychotic), Prozac (antidepressant) and Atarax (anti-anxiety). The medications were stopped at Southport. He averred hearing voices and talking to himself, especially since being off his medications and at Upstate, and that recently a correctional officer gave him a ticket for talking to himself. He reported seeing people in the back of his cell who he knows aren't there. He reported the correctional officers put ideas in his head and make him do things to them. He said he asked for medications over a month ago, and Dr. Kemp, the psychologist, agreed he needs them, but he has still not been to telemedicine yet. Previously, he was on Risperdal and other psychiatric medications and they helped, but he was on no medications when I interviewed him.
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> **Mental status examination:** This man had a bizarre, flat stare, exhibited ideas of reference (paranoia) and strong First Rank Symptoms (a set of signs indicating that an individual cannot discriminate between inner and outer reality, which is a strong evidence of active psychosis). He said he experiences command hallucinations that tell him to do some of the things he gets tickets for
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> **Clinical chart:** This prisoner's thin clinical chart contains diagnoses of "deferred," "Major Depressive Disorder" and "Adjustment Disorder" – i.e. his obvious psychosis is undetected. A 1/9/01 Progress Note states that he had suicidal ideation and he is then sent to observation for six days before being returned to SHU. A 3/16/01 Progress Note states that the prisoner feels hopeless and suicidal due to an additional six-month SHU sentence (on account of refusing to double-bunk and he is sent to observation for six days before being returned to SHU.) On 5/2/01 his medications included the anti-psychotic agent, Risperdal, the antidepressant Serzone, the mood-stabilizer Neurontin, and minor tranquilizers – this is inconsistent with his diagnoses, since he does not have a diagnosis reflecting psychosis or mania.

This prisoner suffers from a serious mental illness with psychosis, but he is inadequately diagnosed. This leads to his confinement in a facility, Upstate, where there are not adequate mental health treatment resources for him and where prisoners with his level of mental health service needs are not supposed to be housed. Then he becomes suicidal and cycles repeatedly to observation from SHU and then back to SHU.

It is cause for concern when OMH administrators note their concern with the size of the OMH caseload, given their limited staffing resources.[20] While it of course makes sense to limit OMH caseload to prisoners actually in need of services, at the same time, if there are more prisoners in need of services than current staff can serve adequately, there is a need to expand the staff. Moreover, because the damage from missing serious cases can lead to tragic results, a correctional mental health department should err on the side of being more inclusive in the case-finding process. I discovered many other prisoners who are suffering from significant emotional symptoms or serious mental illness whose disorders are being missed by mental health evaluations and who are therefore denied services. Here are two of many examples:

> K.F **Interviewed while housed in Keeplock on D Block at Clinton on 7/16/03).**
>
> **History:** This man who speaks broken English was not receiving mental health treatment, but he had been on psychiatric medications in the past because of "voices." He told me he cannot control the tendency to fight. He has not been to CNYPC, has not been in observation, and was not suicidal. In segregation he gets very anxious, cannot concentrate, and has "a lot of trouble remembering things." He has requested more than once to see Dr. Melendez and to receive psychiatric medications for his depression and voices, but he had not been seen. He reported that when isolated in a cell he cannot sleep, he gets agitated and he is unable to control the anger that grows in him.
>
> **Mental status examination:** This man was quite depressed and cried during our interview. There was psychomotor retardation (slowed thinking and behavior) and low self-worth. He gave credible reports of auditory hallucinations.
>
> **Clinical chart:** K.F ; very thin clinical chart contained no diagnosis and few visits with OMH. A 7/9/03 screening note mentioned his problems sleeping and other signs and symptoms of depression and mental illness. But the clinician decided not to put him on the active OMH caseload, noting he would send for his mental health records – but there was no follow-up about those records. An 8/13/03 Screening/Admission Note reported he complains of not sleeping and hears voices. Because he "smiled" the clinician opined there is no mood disorder.

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[20] For example, Dr. Don Sawyer writes in the Annual Report for 2000, "System wide caseload has fallen to 7250 cases (February, 2001). This represents a more manageable total caseload given the staffing resources available to CNYPC Corrections Based Programs...".

K.F. is very depressed and seeks to be in mental health treatment with medications, but is not accepted as a patient by OMH.

N.O. **(Interviewed while housed in SHU on D Block at Clinton on 10/17/03.)**

History: N.O. had received SSI disability on psychiatric grounds since 1986, and entered custody in 1994. He was prescribed Mellaril (anti-psychotic), Haldol (anti-psychotic), Cogentin (an anti-Parkinson agent that is given to treat neurological side effects of the older anti-psychotic agents) and Valium (a minor tranquilizer) prior to incarceration. He had been admitted to the psychiatric ward at Kings County Hospital, and he suffered from EPS (extrapyramidal syndrome, a Parkinson-like neurological problem caused by the older anti-psychotic medications), but he has not been in mental health treatment in DOCS. He has had only a few disciplinary tickets, and the ones that resulted in his SHU term had to do with refusing to program. He had attempted suicide by overdose twice prior to incarceration. He reported he heard voices telling him to jump out of the window. He was feeling anxious and suffered from insomnia. He had not felt that mental health treatment was helpful in other settings, so he has not participated nor requested it while in DOCS.

Mental status examination: This man's flat affect, concreteness and akinesia (listlessness, lack of spontaneity and energy), along with his history, were very consistent with a diagnosis of chronic Schizophrenia.

Clinical chart: His thin clinical chart contained no diagnosis, but OMH screening on 8/1/95 noted history of several inpatient hospitalizations and SSI disability. SHU mental health assessments contained almost no information.

This man appears to suffer from SMI, and is being ignored while he remains in SHU.

There are other problems with the diagnostic process in DOCS and OMH, including insufficient neuropsychological assessment, too little attention to closed head injuries and other neurological deficits, cell-front screening assessments in SHU that produce little useful clinical data and often miss cases of serious mental illness, and a tendency to "un-diagnose" prisoners suffering from serious mental illness who are also disruptive behaviorally or seem manipulative. I will touch on each of these problems later in this Report.

When prisoners suffering from SMI escape detection, they are at the mercy of the disciplinary process and because their mental illness leads to misbehavior, many wind up in isolated confinement.

2. Inadequacies of Mental Health Treatment.

This is a topic I will discuss in more detail in Section VI. For now, I will merely summarize the problem very briefly. Clearly, if mental health services are inadequate, prisoners with serious mental illness will be left to their own devices, and it is in that context that many find their way into isolated confinement, where usually their psychiatric condition deteriorates further. One scenario I discovered in many cases was a failure of OMH staff to spend sufficient time with a psychiatric patient to form a trusting therapeutic relationship, and then, because of the lack of a therapeutic relationship, the patient refused to comply with treatment, failed to go to appointments or discontinued needed medications. Lacking treatment, the patient then engaged in inappropriate behaviors, leading to tickets and isolated confinement. (See Sections IV.D and V.)

3. Inadequacy of CNYPC Space and Criteria for Admission

Today, there are approximately the same number of beds, approximately 200, in the inpatient psychiatric hospital, CNYPC, as there were when OMH began providing mental health services to DOCS in 1977. This is in spite of the fact that the DOCS population has multiplied many times over to the current population of approximately 65,000. In the intervening 28 years, the percentage of total prisoners suffering from serious mental illness has also grown.[21] This means that there are not enough beds for all prisoners whose condition requires admission to an inpatient psychiatric ward. In addition, the criteria for admission to the inpatient unit at CNYPC are essentially equivalent to the criteria for involuntary psychiatric hospitalization in the community – i.e., the patient has to be declared a danger to self or others. This is a very high standard for hospitalization. In the community, many people are admitted to psychiatric wards "voluntarily" because they are experiencing a suicidal crisis or a psychotic breakdown, but they do not meet the criteria for involuntary admission. Clinicians should be able to admit a patient to the hospital in order to perform a thorough clinical assessment, adjust his or her medications, or, for example, to provide early and intensive treatment for an impending breakdown.

As a result of the bed shortage at CNYPC and the overly strict admission criteria, many prisoners who are acutely suicidal or suffering from a breakdown (psychotic decompensation) are managed somewhere else, usually in observation in a Satellite Unit or in isolated confinement.

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[21] Hal Smith, Donald A. Sawyer, and Bruce B. Way, "Central New York Psychiatric Center: An Approach to the Treatment of Co-Occurring Disorders in the New York State Correctional Mental Health System," Behavioral Sciences and the Law, 20: 523–534, 2002.

4. Observation Cells are Another Form of Isolated Confinement

The observation cells I saw are, in essence, another form of isolated confinement, and many of the prisoners I identified as suffering from acute suicidal crises or acute psychotic episodes are kept in observation cells for extended periods without being admitted to CNYPC. In observation there are few activities. The prisoners are rarely removed from their observation cells, except perhaps to meet with a treatment team for a few minutes. There is no recreation, there are rarely visits, and there are extremely restricted amenities. In other words, **prisoners in acute psychiatric crises are consigned to another version of severe isolation, with very limited treatment provided.** There are no "programs" in observation. As I will discuss in Section VI, OMH staff tend to view too many patients as "merely malingering." Malingering is the feigning of illness to achieve secondary gain. The harshness of the observation cells should dispel the notion that prisoners "malinger" to gain access to observation. Many of the patients I interviewed in observation told me they preferred their SHU cell to a cell in observation, and thus, in the many cases where the patient knows he or she will merely be sent to observation, there really is no secondary gain for reporting suicidal thoughts or hallucinations.

5. Insufficient ICP Beds

There are Intermediate Care Programs connected with the Satellite Units (an AVP at Green Haven is roughly the equivalent of ICPs in other institutions), and this is an important component in a comprehensive mental health treatment program. But the 551 beds in the ICPs at 11 institutions with Mental Health Satellite Units is much too small a number relative to the need for an intermediate or "stepdown" level of care [22] In addition, in many of the ICPs I inspected, the prisoners are idle much of the time. (OMH is aware of this problem and documents that postdate the inception of the current litigation indicate that OMH is attempting to ameliorate this problem.)[23]

6. The Unavailability of Vocational, Educational and Other Rehabilitation Programs, as well as Substance Abuse Treatment Programs

In addition to the shortage of activities for prisoners in the ICPs, there is a shortage of vocational and educational and drug treatment programs throughout DOCS. In the community, educational programs such as community colleges and night schools, drug treatment programs and government-run vocational rehabilitation programs, are an indispensable adjunct to comprehensive mental health services. Reductions in recent years in educational, drug treatment, and vocational programs within DOCS has a

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[22] "Stepdown level of care" is intermediate between inpatient psychiatric care and outpatient – see Sect. VI for further discussion.

[23] See "Review of Intermediate Care Program Participants in Program on 9/1/02" by CNYPC.

negative effect on the mental health treatment program. Moreover, these programs are not available to prisoners who are in isolated confinement or observation. There are some cell-study materials, but this is not an adequate substitute for congregate, staff-facilitated and supervised programming. Many prisoners are functionally illiterate (40% according to research[24]) and not capable of studying written materials; many others are so anxious and have such impaired concentration on account of the conditions of isolated confinement that they are not able to make use of cell-study materials. **In any case, cell-study is not an adequate substitute for the social interactions that are a critical component of any mental health treatment.**

7. **Prisoners Who Exhibit Serious Mental Illness as well as Serious Discipline Problems are Excluded from ICP and other Treatment Programs; and are subject to longer periods of isolated confinement and even more time in prison.**

Shortfalls in the mental health delivery system result in inadequate treatment of prisoners suffering from serious mental illness. One glaring effect of this inadequate treatment is that prisoners suffering from SMI - when left to their own devices, or when their medications are not monitored closely enough, or when they are left idle and insufficiently supervised – tend to get into trouble. In NY DOCS, trouble frequently means getting tickets and winding up in SHU.

A SHU sentence has other major negative consequences. For example, disciplinary sanctions may jeopardize a prisoner's chances for parole. Also, as a result of disciplinary infractions a prisoner can receive a disposition that recommends the loss of "good time." The impact of either parole denial or loss of "good time" is a longer period of incarceration.

I interviewed many prisoners currently confined in SHU in various facilities who are suffering from serious mental illness, only to discover that they have requested placement in an Intermediate Care Program (ICP), or that they were previously in an ICP and their mental condition was stable while they were in the program. I also discovered that after they left the ICP, they received more tickets, they were re-admitted to observation or CNYPC more often, and in general their condition deteriorated. When I asked them why they are not in ICP now they told me "I got a ticket." I also interviewed quite a few prisoners who eventually were admitted to ICP after serving long terms in SHU, and they told me that they had to serve their SHU term first before they could be admitted to ICP. I learned that there is a policy that permits OMH staff, in collaboration with security staff, to recommend "time-cuts" so that prisoners suffering from mental illness can be transferred from SHU to ICP where they are more likely to receive the treatment their psychiatric condition requires.

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[24] The Center on Crime, Communities, and Culture, "Education as Crime Prevention." Research Brief, Occasional Paper Series, Sept., 1997, Vol. 2, New York: Center on Crime, Communities, and Culture.

My sense is that "time-cuts" are mentioned often (and there are several policies regarding time-cut procedures) yet in too many cases these do not result in very significant reductions, if any, in the term a prisoner with SMI must serve in SHU. For these and related reasons, I have concluded that, for the most part, ICP is reserved for prisoners with SMI who are capable of behaving themselves and avoiding Tier 3 tickets. Those who are less capable of behaving appropriately are relegated to isolated confinement in SHU. I have already presented the case of N.P. who was discharged from ICP for bad behavior. Other illustrative cases to be found in this Report include A.M., V.J., D.D.X., E.E.Z. and T.R., and in Case Studies, Appendix D, including G.G.A. and X.F.. Safe management of the expectable misbehaviors and outbursts of individuals suffering from serious mental illness must be part of the range of treatment interventions if a mental health system is to provide comprehensive services. NY DOCS and OMH do not provide this as an option. In NY DOCS, the patient is often expelled from the treatment program that fits his level of need, for example ICP, if he misbehaves, and he is sent to SHU. The following case illustrates the problem:

D.R.. **(Interviewed while housed in SHU at Clinton on 7/15/03).**

History: This man came to the SHU at Clinton months earlier after discharge from CNYPC, where he'd been admitted because he was not eating. He reported he had been to CNYPC 30 times. In the past he has been in ICP at Elmira and Attica, and says he did much better while in ICP. Because he acts out and receives tickets when he is emotionally unstable, he is discharged from observation or CNYPC to SHU rather than being returned to ICP. When he is in SHU he does not talk to anyone, but he walks on the yard for an hour when he is permitted to go there. He is unable to control his temper when he is in SHU, and typically gets into disputes with staff, often leading to additional tickets and a longer SHU term.

Mental status examination: This man has depressed mood with psychomotor retardation and a sense of worthlessness, consistent with severe depression. There are signs of a thought disorder, consistent with psychosis.

Clinical chart: His chart reflects that he was admitted for the 15th time (first admission was in 1984) to CNYPC on 2/14/03, having lasted "a day or two in SHU" before his condition deteriorated, his hygiene was terrible and he was disoriented. His diagnosis was Depressive Disorder NOS, and he was prescribed the anti-psychotic medication, Risperdal 2 mg. He was sent to CNYPC from SHU because of danger to himself, threatening to hang up, disheveled appearance, refusal to eat, and "rapid mood cycling,

incoherent and illogical." He has made many attempts at self-harm, including hanging up. He had been in the past in ICP at Elmira and at Attica, and adjusted relatively well there, but he continued to be re-admitted to CNYPC, "disheveled," disorganized and appearing psychotic. A 3/12/03 note diagnoses Schizophrenia, Undifferentiated Type vs. Schizoaffective Disorder. When discharged from CNYPC in 3/03, the recommendation was that he be sent to STP. Instead he was returned to SHU without being admitted to STP.

D.R. suffers from Schizophrenia and is repeatedly admitted to CNYPC. He is known to do well in ICP, and yet he is returned from CNYPC to SHU, where he has repeatedly deteriorated.

8. The Disciplinary Process Fails to Give Sufficient Consideration to Mental Health Issues

The Disciplinary Process fails to adequately take a prisoner's mental illness into consideration in the meting of punishments, and there are disciplinary repercussions for acts that are driven by mental illness such as self-harm, failing to follow direct orders, unhygienic acts, flooding or setting fire to their belongings. Both of these unfortunate realities increase the number of prisoners with SMI who are given a SHU term as punishment for a disciplinary ticket, and when prisoners with SMI are serving a SHU term and receive another ticket, as they are prone to do, their term in SHU is effectively lengthened. There is a tendency for staff (security and mental health staff) to respond to rule-breaking and misbehavior on the part of prisoners suffering from mental illness with punitive interventions, disciplinary write-ups that can result in additional terms in SHU, cell extractions and other uses of force.[25] Even when a prisoner is placed in observation for self-destructive acts, the conditions are punitive and often there is a pending disciplinary ticket, perhaps for the self-harm act itself, which will lead to an even longer term in SHU.

I spoke to many prisoners who claim symptoms of mental illness caused the behaviors that led to tickets – hallucinated voices commanded them to do something wrong or attempt suicide, for example – and then either OMH staff provided the hearing officer with an opinion that their mental illness did not have an effect on their rule-breaking behavior or OMH was not involved in the disciplinary process at all. Since my tours and interviews, the Settlement Agreement in the Anderson litigation has been effected. According to that Settlement Agreement, OMH staff are required to intervene with Hearing Officers when prisoners on the OMH caseload have hearings for disciplinary infractions. There are a prescribed set of questions about diagnosis, psychiatric medications, mental state at the time of an infraction and so forth, and I have reviewed the relevant training documents. I am not in a position to assess the

[25] As set forth below, I believe insufficient training about mental illness and staff burnout are also contributing factors. See Section VI.

effectiveness of the procedures put in place since the Anderson Settlement Agreement was instituted, but in the following illustrative case, and in many other cases I describe in this report, prisoners' mental illness is not being taken into serious consideration during disciplinary hearings and prisoners are being given SHU terms as punishment for acts that are driven by their mental illness. Furthermore, for prisoners who accrued lengthy SHU sentences prior to the Anderson settlement and are presently serving these sentences, the settlement will have limited effect on the length of time they serve in SHU. I describe below one of the many relevant cases I encountered.

O.P. **(Interviewed while housed in SHU at Clinton on 7/15/03).**

History: This man has been in and out of prison for seven years. He has been admitted to CNYPC three times. He says most of his tickets are for refusing mental health call-out. He does not know why he is currently in SHU. He says he takes psychiatric medications but does not know which ones. He denies hearing voices: rather, he says he talks to himself.

Mental status examination: O.P. has some problems with orientation and memory, besides seeming flat and confused. While he denies hearing voices, he seems internally preoccupied as if hearing voices, his thinking is tangential and sometimes bizarre, and there is evidence of paranoia.

Clinical chart: There is a 11/2/99 diagnosis of Schizophrenia, Disorganized Type, and a 7/16/02 diagnosis of Schizophrenia with prescription of Zyprexa and Prolixin, and on 7/24/00 Mild Mental Retardation is diagnosed with IQ 65. Psychiatric hospitalizations prior to incarceration are noted. He was at CNYPC from 12/02 until 5/7/03, transferred from Great Meadow SHU and back to Great Meadow SHU. Memory problems are also noted.

O.P. is clearly suffering from psychosis, probably Schizophrenia, but also has limited intelligence (his IQ is listed as 65) and possible organic brain disorder. Indeed, Mr. Brown was identified at Reception as suffering from both serious mental illness and mental retardation, and was referred to SNU (the Special Needs Unit for mentally retarded prisoners) – but the recommendation was never followed.[26] Instead, he is given ever longer SHU sentences for impulsive behaviors that occur while he is disorganized and psychotic. He was considered and rejected for STP at Five Points because of his behavior problems and intermittent non-cooperation with treatment. Even after being accepted to STP, he sits in SHU without STP programming because there is a long waiting list for STP admission. OMH staff agree SHU is an inappropriate place for him, given his mental problems, and yet he is disciplined (and, further, prosecuted) for

[26] See Section VII.H for more detailed discussion of Special Needs Unit.

actions that are symptomatic of his mental illness and his condition worsens in SHU confinement.

Further details about O.P. clinical course are contained in the Deposition of Dr. Algimantas Shimkunas (6/3/2004). From Mr. Shimkunas' deposition (pp. 167-201), it becomes clear that this prisoner is viewed as presenting both treatment and security problems. Dr. Shimkunas is aware that he had been admitted to psychiatric hospitals in the community prior to incarceration and had been repeatedly diagnosed Schizophrenic in OMH/DOCS, but his diagnosis was changed at some point to Impulse Control Disorder at CNYPC. Dr. Shimkunas has testified at disciplinary hearings about this prisoner, utilizing progress notes from the clinicians who see him. Dr. Shimkunas believes this prisoner would benefit from STP, and placed him on the list for consideration. However, O.P. still waits for placement in STP, and will not be admitted any time soon because, according to Dr. Shimkunas, "there are over 40 patients on the wait list." But Dr. Shimkunas believes any prisoner who has assaulted staff cannot be in ICP. Dr. Shimkunas agrees that a progress note by Dr. Faruki reflected "The patient's speech and behavior are very disorganized. He smears feces in his cell. He has been seen to eat his feces. His speech is incoherent and irrelevant. He refuses to take his medications." Dr. Shimkunas acknowledges that similar behaviors, related to this prisoner's mental illness, led to an outside court prosecution and additional time in SHU. When (p. 188) Dr. Shimkunas was asked a summary question, "So some of the similar behaviors of smearing feces or throwing or flooding may indeed have resulted in an additional criminal charges for this individual?," Dr. Shimkunas replied, "That's right." Dr. Shimkunas offered no response to the question whether it is appropriate to criminally charge a prisoner for behaviors driven by his mental illness, except to repeat that DOCS prosecutes such cases. When presented with a 1/26/01 memo from Sullivan Correctional Facility pre-dating O.P's transfer to Great Meadow, which ends with a statement that there is a plan to get this man out of SHU because of his serious mental illness so he can receive proper treatment, Dr. Shimkunas acknowledges that that letter (documenting there had been a plan in place to get O.P. out of SHU for three and a half years) was not considered by the clinicians working with Mr. Brown at Great Meadow when he faced disciplinary proceedings. I will mention another case.

V.H. **(Interviewed while housed in SHU at Elmira Correctional Facility on 3/11/03.)**

History: V.H. has been in prison for three years and says he is due to be released in one month. In further conversation, it became clear that he was quite delusional and believes that he will be released in a month only because he did a heroic act for which officers are grateful. He has been in the SHU for two years, and said he was transferred to CNYPC on three occasions. He has not gone to recreation because there is no equipment and nothing to do in the recreation area except walk around in circles. He told me he must get up at 6 A.M. and request an appointment

with mental health staff, or he is not seen. He was taking Zyprexa (an atypical anti-psychotic medication), 10 mg./day.

Mental status examination: V.H. was actively delusional during the interview; he talked about officers putting something in his food that disturbs his sexual function. He believes officers were sexually abusing him and reported more detailed delusional material, mostly sexual in content. He exhibited flat affect, delusional thinking with strong ideas of reference and very poor reality testing, rigid thinking, and slowed cognition. His judgment was poor and he was unable to abstract. His delusional thinking invades his sense of orientation. In other words, there is much evidence of active psychosis, which seems to reflect persistence of a chronic serious mental illness.

Clinical chart: The chart confirms much of his history. A 2/26/02 note contains the diagnoses Delusional Disorder and Intermittent Explosive Disorder, and it is noted he believes "People reading his thoughts with machines. Grandiose delusions 'I'm supposed to be a famous rapist.'" He was transferred to CNYPC, his first admission, where a 4/02/02 Core History notes a past history of psychiatric hospitalization prior to incarceration for three weeks in 1998. Zyprexa, 15 mg./day was prescribed.

At the time of a disciplinary hearing following an alleged May 17, 2001 assault on officer(s), this prisoner was thought to be suffering from "Intermittent Explosive Disorder." He had been prescribed Neurontin (a mood stabilizer), 600 mg./day, but had not taken that medication for a week prior to the alleged assault. It cannot be ruled out that at the time of the incident he was either suffering from acute symptoms of what would later emerge and be diagnosed as psychosis, or that he was having a transient psychosis-like reaction to rapid cessation of Neurontin. The fact that he developed a full blown psychosis months later, with organized paranoid delusions (which take quite some time to evolve, and were probably already evolving at the time of the incident), points to a strong possibility that he was becoming paranoid in the week prior to the 5/17/01 incident. But his mental condition seems not to have been assessed prior to the disciplinary hearing.

Clearly V.H. suffers from psychosis, probably delusional disorder, and he decompensates in SHU. His SMI is not sufficiently considered when he faces a disciplinary hearing.

E. Prisoners with Serious Mental Illness Acquire Ever Longer SHU terms.

There are many practices and policies (including, among others, those described above) that extend the time in SHU for prisoners suffering from SMI. For example, many prisoners suffering from serious mental illness receive even more tickets after entering SHU, very often because of deterioration in their psychiatric condition that results from SHU confinement, and then their term in SHU is repeatedly extended. The case below illustrates the problem. Of course, many of the other cases I describe throughout this Report also illustrate this problem.[27]

Q.I **(Interviewed while housed in SHU at Clinton on 7/15/03.)**

History: This man has been in prison for five years on his second prison term. He has been in SHU since 2001. He has a long psychiatric history. He is prescribed Zyprexa, 25 mg. per day, a relatively high dose of a strong anti-psychotic medication. He entered SHU for a six month term but has received more tickets while in SHU. When I asked him why that is the case, he said he gets tickets in SHU because being in SHU makes him lose control of his temper and become paranoid and depressed. He reads a little, but is concerned about a very short attention span.

Mental status examination: There was flat affect and concreteness, consistent with history. No signs of acute exacerbation of psychosis. Gave credible account of hallucinations.

Clinical chart: His chart reflects a single CNYPC admission in May, 2003. He had a diagnosis Psychotic Disorder NOS at that time, and exhibited regression and "word salad" (a nonsensical stream of words). Prior notes include an urgent transfer from Upstate to Clinton on 8/16/01: "Undifferentiated Schizophrenia with history of suicidal ideation, auditory hallucinations, (mental status:) unstable, not oriented to time, place, some delusional thinking, and a diagnosis of Brief Psychotic Disorder." Other notes date to 2000, and consistently diagnose Schizophrenia. He has been prescribed Zyprexa and Paxil, among other medications.

Clearly Q.I. suffers from recurring psychosis and should not be in SHU, where his symptoms worsen; in SHU, he cannot control his temper, and he receives more

[27] These include J V.M., Y.H., N.D., I.A., A.M., C.C.A., X.F., J.Z., W.C., D.R., Q.I., B.B., Y.Y., C.Y.N., I.V., P.J., R.X., D.D.X., E.E.M., A.L., C.E. and T.Y.

tickets that lengthen his term in SHU. It is inappropriate to confine Q.I. in SHU at Upstate due to the limited mental health services at that facility (see Section VI.I). The behaviors that lead to subsequent tickets are likely driven by his worsening serious mental illness.

F. Prisoners with Serious Mental Illness in Isolated Confinement are Not Diagnosed or are Un-diagnosed

At some point, many prisoners suffering from serious mental illness in SHU are essentially "un-diagnosed," meaning their diagnosis is changed from a serious mental illness such as Schizophrenia to a less serious diagnostic category such as Polysubstance Abuse or an "Axis II" personality disorder such as Antisocial Personality Disorder.

In other words, they are no longer viewed as "mad," rather they are considered "bad," and henceforth their unacceptable behaviors will be met with punishments rather than more intensive psychiatric treatment. I will discuss un-diagnosis, malingering, psychopathy and so forth in Section VI. Here, I will outline the sequence of events I discovered in many cases I reviewed in NY DOCS, and then I will provide one illustrative case:

- There is a long history of documented mental illness, including suicide attempts, psychiatric hospitalizations and treatment with psychiatric medications with good effect, in many cases dating back to childhood and pre-dating incarceration. Often the prisoner had been on Social Security Disability benefits for psychiatric impairment in the community or had his competency questioned by the courts.

- When the prisoner is treated in the community or in prison for serious mental illness he is relatively functional between "breakdowns" (the term of art is "decompensation"), but when treatment is discontinued he becomes dysfunctional and unmanageable, even by correctional standards. He violates rules or becomes assaultive and receives disciplinary tickets.

- He is transferred to SHU just prior to marked deterioration of his mental health condition. Either he receives the ticket that sends him to SHU while experiencing evolving psychiatric symptoms such as confusion or command hallucinations, or his psychiatric condition deteriorates after he spends a period of time in SHU.

- In spite of a clear and obvious history of serious mental illness, at some point a decision is made that he or she is not actually suffering from serious mental illness; rather, he is merely suffering from a minor form of emotional distress such as "Adjustment Disorder," or is "manipulative" or "malingering," or suffers mainly from an Axis II diagnosis such as Antisocial Personality Disorder or Psychopathy. In other words, prisoners who had been diagnosed with persistent serious mental illness are "un-diagnosed."

- Treatment is de-emphasized or discontinued, the inappropriate or self-destructive behaviors are viewed as willful manipulations, and the prisoner is subjected to further punishments, usually involving even more time in SHU and more deprivations. This problem is magnified when the Mental Health Level is inaccurate. I found many prisoners with active and disabling serious mental illness at Upstate and Southport. This should not happen, because they should be considered Mental Health Level 1 or 2, and therefore, by policy, excluded from Upstate, or Level 1 and therefore excluded from Southport.

- He or she accumulates even more disciplinary tickets, many that appear as if they might be driven by symptoms of a worsening and inadequately treated mental illness. Included may be tickets and lengthy terms in isolated confinement for symptomatic acts, such self-harm, unhygienic acts, flooding and setting fire to belongings.

- Since his or her mental illness has been un-diagnosed and subsequent unacceptable behaviors are attributed to "badness" rather than "madness," punitive measures are instituted. These are often codified in Behavioral Management Plans. For example, he might be forced to remain naked except for a gown in a cold observation cell with few if any amenities, and he may be required to eat cold "loaf" instead of hot meals, and he may be precluded from future admissions to the psychiatric hospital, and clinical interventions for subsequent emotional crises may be ordered delayed or withheld.

- The harsh conditions of confinement and deprivations exacerbate the mental illness, and the prisoner acts out even more, but because staff have decided he or she does not suffer from a serious mental illness, continuing pleas for help are viewed as further manipulations and the possibility that he or she has been erroneously un-diagnosed is not given much thought.

The following case illustrates this general sequence:

B.Q. **(Interviewed while housed in General Population at Clinton on 7/16/03).**

History: This man spent nine years in SHU (or other form of isolated confinement). French is his primary language. He believes he was drugged and that is why he is confused now. He has a history of drug abuse. He claims he was admitted to the psychiatric ward at Bellevue Hospital prior to incarceration, and he insists voices come into his cell through the vent.

Mental status examination: This man is quite delusional, tangential and incoherent. He tells a long delusional story about how he was drugged, he describes a device that was used to control his mind by a woman he met in Bangkok, and he explains various colors he sees. When asked about his

psychiatric history, he denies he has a mental problem, starts to talk about being in observation in Feb., 2003, and then the story drifts into tangential incoherence.

Clinical chart: There is movement back and forth between Mental Health Level 1 and Level 6; a stay in observation on 2/6/03 because of paranoid delusional thinking involving druggings and the FBI; an admission to CNYPC on 2/14/03; notes documenting delusions and diagnoses of Delusional Disorder, Adjustment Disorder with Disturbance of Conduct, and possibly Bipolor Disorder; mental status reflecting odd thinking, illogical and incoherent speech; loud, rapid pressured speech; a delusional belief he was being brainwashed through his penis; no psychiatric medications because he refused to take them; and discharge from CNYPC on 3/12/03. Even though he was admitted to CNYPC because of delusional thoughts and confusion, the discharge note changes his diagnosis to Adjustment Disorder with Disturbance of Conduct, and no medications are prescribed because he refuses. But even the narrative hospital notes reflect delusional thinking and other signs and symptoms of psychosis. There is no attempt in the chart to reconcile the observed signs and symptoms of psychosis with the discharge diagnosis.

B.Q. , very delusional and psychotic. He is obviously suffering from a serious mental illness, probably Paranoid Delusional Disorder (possibly Schizophrenia). He says he does not want mental health treatment, but he has been admitted to CNYPC and observation, and was evidently discharged from the OMH caseload on 4/3/03 after he was un-diagnosed, i.e. his diagnosis was inappropriately downgraded from Delusional Disorder (a serious mental illness) to Adjustment Disorder. No responsible mental health clinician would have discontinued the Delusional Disorder diagnosis in the face of B.Q. , symptomatology and psychiatric history. As a result of this un-diagnosis, mental health treatment efforts ceased, with obvious detrimental effects on B.Q. , who was severely psychotic by the time I interviewed him.

Other cases wherein a prisoner's diagnosis is improperly downgraded or the prisoner is undiagnosed are discussed in some detail later in this Report[28]; like many of the other problems described in this section "The Path to Isolated Confinement for Prisoners with Mental Illness," the problems that lead to so many prisoners with SMI being housed in isolated confinement reflect serious problems in the delivery of mental health care to all prisoners in DOCS. See Section VI.

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[28] See, for example, cases such as T.R. , V.J. , E.S. , D.D.B. , A.L. and others. Many of the above cases (and others like them) are included in Section VI of this Report.

G. Prisoners with Serious Mental Illness Cycle Repeatedly From SHU to Observation or CNYPC and Then Back to SHU

A vicious cycle evolves, in which a subset of prisoners suffering from serious mental illness are housed for long periods in SHU on account of bad behavior, but periodically become acutely psychotic or suicidal and have to be transferred to observation or CNYPC. After they settle down, and their medications are adjusted, they are sent back to SHU, where their condition deteriorates until they need to be sent back to observation or CNYPC again. OMH's own clinicians recognize this cycle.[29]

There is also another kind of vicious cycle that leads to heightened animosity between prisoners and staff. When human beings who are suffering from serious mental illness are subjected to extremes of isolation and idleness, and are denied social contact and just about all lack the means to express themselves in a constructive manner, it is entirely predictable that they will resort to increasingly desperate and bizarre acts to achieve some degree of control of their situation and to restore some modicum of self-respect. The disturbed prisoners in isolated confinement who are suffering from serious mental illness are then likely to be perceived by officers as disrespectful or rule-breaking; the officers, in turn, become increasingly insensitive, punitive or even abusive toward the identified troublemakers.

Prisoners housed in isolated confinement have been deprived of just about all the amenities and freedoms we usually take for granted as basic human requirements. They continue to be dissatisfied with their plight and they get into further trouble with staff. There is then little else that correctional staff can take from them. Through the disciplinary process, prisoners can then be put on a restrictive diet (the "loaf"). In addition, security staff can order a cell shield, a lexan cover over the front of the cell, which further restricts air circulation and communication. Such deprivations and humiliations cause suffering, and in many cases more symptomatic behavior, in prisoners with serious mental illness. Thus, a prisoner who is hearing voices or who is seriously contemplating suicide may find himself in an isolation cell behind lexan, eating cold "loaf," and his growing rage makes the voices in his head seem louder or his thoughts of suicide more compelling. The scene is shockingly reminiscent of the bedlam that prevailed in the back wards of state hospitals in the 1940s and 1950s.

Often it seems that the more prisoners cycle, the more firmly mental health staff are convinced certain prisoners are "bad" and not "mad," the more tickets these prisoners receive, and the longer their SHU term becomes. According to the Correctional Association of New York: "From our sample, the minimum SHU sentence was one month; the maximum sentence was 12 years. **Noteworthy is that the average**

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[29] In a presentation dated May 27, 2003, John S. Wilson, Ph.D., then chief psychologist of CNYPC, described the following cycle: disciplinary confinement, mental deterioration, transfer to CNYPC, stabilization and transfer back to disciplinary confinement, where the cycle begins again. (Pl. Ex. 466).

SHU sentence reported by inmates with mental illness in our sample was six-and-a-half times longer than that of inmates generally: 38 months compared to the Department's figure of 5 months for inmates generally "[30]

I have already described a number of such cases, but I will include one more here, a case that illustrates many of the points I have made in this section:

> T.R. **. (Interviewed while housed in SHU at Clinton on 8/26/03).**
>
> **History:** This man has been in prison since 1994. He explained he is in observation because he stopped taking his Lithium (mood-stabilizer prescribed for Bipolar Disorder) and Thorazine (older anti-psychotic). He believes the Thorazine made him see things on the walls, and he reported this to OMH staff. He was admitted to Mid-Hudson Hospital three or four times while in jail; he has been admitted to CNYPC twice since admission to DOC. He was in ICP at Clinton, but was placed on Keeplock and removed from ICP. He has a history of command hallucinations linked with suicide attempts prior to incarceration. He was placed on Keeplock for throwing cereal; he reports that he believed the staff were playing with his food and the cereal had hairs in it.
>
> **Mental status examination:** T.R. appeared agitated, confused, disoriented, and internally preoccupied as he talks about voices. His speech was slowed, he stared in a bizarre manner, and clearly suffered from ideas of reference. He cannot abstract. He told me he cannot read because weird thoughts intrude into his consciousness. He had very strong First Rank Symptoms (signs of psychosis that are very difficult to feign – see Section VI.I.2).
>
> **Clinical chart:** His chart repeatedly reflects many suicide attempts, depression and paranoia, with borderline or low intelligence. On 10/31/02 he was admitted to ICP with diagnoses of Psychotic Disorder NOS and Borderline Intellectual Functioning. He was prescribed Risperdal (3 mg. b.i.d.) plus Vistaril (a minor tranquilizer) and Benadryl, but took them inconsistently, so medications were discontinued on 11/26/02. In an ICP Progress Note, it is reported that he has "extensive history of inpatient psychiatric treatment" dating back to 1995. On 3/23/03 he is discharged from ICP with a note he has been in four fights while there and will not be accepted back in ICP, even though the ICP discharge note reflects paranoia, depression and hallucinations, and a diagnosis of Psychosis NOS. By 3/31 he was in observation. He is sent to Upstate, but a 4301 transfer to Great

[30] See The Correctional Association of New York, "Mental Health in the House of Corrections," June, 2004.

Meadows is arranged because "There is no way he's going to make it in this facility" (Upstate). In June, 2003, he was sent to CNYPC with a diagnosis Psychotic Disorder NOS. Notes from CNYPC include a long psychological assessment by Dr. Michael Guariglia, with diagnoses of ASPD on Axis II and non-compliance with treatment on Axis I. Nevertheless, the psychologist claims there is no major mental illness. A 7/22/03 Behavior Management Plan recommends that he not be sent back to CNYPC. Still, he is given multiple injections and pills of Thorazine 150 mg, Haldol, etc. A 7/28/03 psychiatric consult notes he is not suffering from Psychosis NOS, nor Mental Retardation, but has Antisocial Personality Disorder. Nevertheless, a few weeks later, on 9/2/03, it is noted that he "seems to be listening to inner voices... and talking to himself." Paranoia is noted on 9/16/03. He was subsequently re-admitted to CNYPC and released in April, 2004 (per NY DOCS website).

T.R. was clearly acutely psychotic when I interviewed him on 8/27/03. He had recently returned from CNYPC where he was un-diagnosed and put on a Behavior Management Plan. Still, progress notes reflect active psychosis and paranoia, and he is on dosages of anti-psychotic and mood stabilizing medications that would not be appropriate for someone who does not suffer from a serious mental illness. In spite of the un-diagnosis, he continues to cycle from SHU to observation and CNYPC and then back to SHU. As a result of OMH staff's "un-diagnosing" him, a coherent treatment plan is lacking, leaving him little chance of maintaining emotional stability.

V. The Effect of Isolated Confinement on Prisoners with Serious Mental Illness

A. The Phenomenon

It has been known for as long as segregated housing has been practiced in prison that human beings suffer a great deal of pain and mental deterioration when they remain in isolated confinement for a significant length of time. (I employ the term "isolated confinement" to include punitive segregation as well as restrictive housing of any kind, including Special Housing Units or (SHU), Keeplock and other situations within NY DOCS where prisoners are confined to their cells for nearly 24 hours per day, eat meals in their cells, and there is near total isolation and idleness). This is especially the case for prisoners who suffer from mental illness. Thus, in 1890, the U.S. Supreme Court found that "[a] considerable number of prisoners fell, after even a short confinement [in isolated confinement], into a semi-fatuous condition, from which it was next to impossible to arouse them, and others became violently insane; others still, committed suicide; while those who stood the ordeal better were not generally reformed, and in most cases did not recover sufficient mental activity to be of any subsequent service to the community."[31] In fact, New York's Auburn Correctional Facility was the location of an experiment with

[31] In re Medley, 134 U.S. 160, 168 [1890].

prolonged isolation in the Nineteenth Century, which was declared a "hopeless failure" by historian Harry Elmer Barnes, who writes that it "led to a marked prevalence of sickness and insanity on the part of the convicts in solitary confinement."[32]

Human beings require some degree of social interaction and productive activity to establish and sustain a sense of identity and to maintain a grasp on reality. In the absence of social interactions, unrealistic ruminations and beliefs cannot be tested in conversation with others, so they build up inside one's mind and are transformed into unfocused and irrational thoughts. Without social interactions, individuals have no way to test the reality of their fantasies, and thus there is a tendency toward paranoia and an inability to control the rage that mounts with each perceived insult.[33]

Productive activities serve as a basis for testing the reality of imagined thoughts, for maintaining a sense of one's worth or self-esteem, and for testing the wisdom of acting out inner impulses, and they provide a necessary outlet for physical and psychological energy. Where productive activities are severely restricted, the resulting idleness multiplies the effects of social isolation.

Prisoners in segregation do what they can to cope. Many pace relentlessly. Those who can read books and write letters. But many prisoners are illiterate. Nationwide, at least 40% of prisoners are functionally illiterate,[34] and evidence is accruing that illiterate prisoners fare less well than others in isolated confinement. This makes sense; if one is alone in a cell nearly 24 hours per day and cannot even read the newspaper or write a letter, the sense of unreality and isolation is likely to grow. Prisoners prone to or suffering from mental illness have even more difficulty concentrating than do others, and many, on account of anxiety or hallucinations or obsessions or despair, find it impossible to read or write while restricted to a cell. I interviewed many prisoners in the NY DOCS who cannot or do not read or write. Some are illiterate, some have been denied pen and paper for disciplinary reasons or because staff fear they might harm themselves, and some

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[32] H. E. Barnes, "The Historical Origin of the Prison System in America, Journal of Criminal Law and Criminology 35-60, 1921, p. 53, cited in amicus brief by mental health experts to U.S. Supreme Court in Wilkinson v. Austin, March, 2005, p. 8

[33] An example from everyday life in the community: I walk into a room, two people are talking and lower their voices as I enter. I have the momentary fantasy they were talking about me and that's why they lowered their voices when I walked in; I approach them and their friendly greetings disabuse me of what I now can judge to be an erroneous and paranoid fantasy on my part. This kind of reality testing goes on in everyone's daily life. We have suspicions, negative thoughts and fears, and our subsequent interactions with others permit us to test their reality. Prisoners in isolated confinement have no opportunity to "check out" their possibly paranoid projections with a sympathetic friend. This is merely one example of the debilitating effects of such confinement.

[34] The Center on Crime, Communities, and Culture, "Education as Crime Prevention." Research Brief, Occasional Paper Series, Sept., 1997, Vol. 2, New York: Center on Crime, Communities, and Culture.

are so plagued by inner ruminations or so dominated by anxieties or hallucinated voices that they cannot sustain the concentration required to read or write.

In the context of near-total isolation and idleness, psychiatric symptoms emerge in previously healthy prisoners. For example, a prisoner may feel overwhelmed by a strange sense of anxiety. The walls may seem to be moving in on him (it is stunning how many prisoners in isolated confinement independently report this experience). He may begin to suffer from panic attacks wherein he cannot breathe and he thinks his heart is beating so fast he is going to die. Almost all prisoners in SHU tell me that they have trouble focusing on any task, their memory is poor, they have trouble sleeping, they get very anxious, and they fear they will not be able to control their rage.[35] Other researchers report these symptoms in a large majority of prisoners in isolated confinement.[36] The prisoner may find himself disobeying an order or inexplicably screaming at an officer, when really all he wants is for the officer to stop and interact with him a little longer than it takes for a food tray to be slid through the slot in his cell door. Many prisoners in isolated confinement tell me it is extremely difficult for them to contain their mounting rage, and they fear losing their temper with an officer and being given a ticket that will result in a longer SHU term.

B. The Literature

Social scientists have been studying the effects of isolated confinement for many years. In an early study, Cormier and Williams studied 21 prisoners in prolonged segregated status and noted a marked increase in verbal aggression, physical destruction of surroundings and development of paranoid ideas, in some cases related to evolving psychosis.[37]

Hans Toch summarizes the hundreds of interviews he did with prisoners, many in long-term isolated confinement in New York State DOCS correctional facilities.[38] He coined the term "isolation panic" for the symptoms he regularly discovered in the men, including panic, rage, a sense of total loss of control, an experience of emotional breakdown; many exhibited very regressed behavior and many resorted to self-

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[35] OMH has long known about this problem. See 10/15/03 Email from Don Sawyer to Richard Miraglia and Hal Smith [OMHCNY 089934-089936].

[36] See B., below.

[37] Bruno Cormier & Paul Williams, "Excessive Deprivation of Liberty, Canadian Psychiatric Association Journal, 11, 470-484, 1966.

[38] Toch, Hans, Men in Crisis: Human Breakdown in Prisons, Chicago: Aldine, 1975, pp. 20.

mutilation[39]. Toch distinguished between incarceration, which is difficult but tolerable, and isolated confinement, which is not tolerable for many.

Social psychologist Craig Haney has conducted research with a large number of prisoners in isolated confinement. He randomly selected prisoners and found very high prevalence rates for a large list of emotional symptoms. Over 80% of the prisoners reported massive anxiety. Likewise, over 80% of the prisoners complained of headaches, troubled sleep, and lethargy. Over half complained of nightmares, heart palpitations, violent fantasies, depression or despair, and fear of impending nervous breakdown. Complaints of obsessive ruminations, confused thought processes, oversensitivity to stimuli (a strong startle reaction), irrational anger and social withdrawal were widespread.[40]

Psychiatrist Stuart Grassian examined a large number of prisoners during their stay in segregated, near-solitary confinement units and concluded that these units, like the sensory deprivation environments that were studied by psychologists in the 1960s, often induce psychosis, especially in prisoners who have histories of mental illness or a predisposition to psychiatric breakdown.[41]

I will not review all of the research literature here, but there has been a substantial amount of research into the harmful effects of isolated confinement, especially if the prisoner thus confined suffers from a serious mental illness or is vulnerable to mental illness. In their amicus brief in Wilkinson v. Austin, leading mental health experts summarize the clinical and research literature about the effects of prolonged isolated confinement and conclude: "No study of the effects of solitary or supermax-like confinement that lasted longer than 60 days failed to find evidence of negative psychological effects" (p. 4).

It has been my experience, from tours and well over a thousand clinical interviews with prisoners in isolated confinement units in ten states, that the conditions that cause emotional distress in relatively healthy prisoners cause psychotic breakdowns, severe

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[39] Ibid., pp. 38-43.

[40] Haney, Craig, "Mental Health Issues in Long-Term Solitary and 'Supermax' Confinement," Crime & Delinquency, 49,124,127, 2003.

[41] Even prisoners who do not become frankly psychotic frequently report a number of serious psychiatric symptoms, including but not limited to: a. Massive free-floating anxiety; b. Hyper-responsiveness to external stimuli, including a startle response; c. Perceptual distortions and hallucinations in multiple spheres (auditory, visual, olfactory); d. Derealization experiences; e. Difficulty with concentration and memory; f. Acute confusional states, at times associated with dissociative features, mutism, and subsequent partial amnesia for those events; g. The emergence of primitive, ego-dystonic aggressive fantasies; h. Ideas of reference (paranoia) and persecutory ideation, at times reaching delusional proportions; i. Motor excitement, often associated with sudden, violent destructive or self-mutilatory outbursts; and j. Rapid reduction of symptoms upon termination of isolation. Grassian, Stuart, "Psychopathological Effects of Solitary Confinement," American Journal of Psychiatry, 140, 11, 1450-1454, 1983.

affective disorders and suicide crises in prisoners who have histories of serious mental illness, as well as in a certain number of prisoners who never suffered a breakdown in the past but are prone to break down when the stress and trauma become exceptionally severe. Also from my experience, I have determined that the longer the period of isolated confinement, the more likely that these negative effects will occur (although in some cases of serious mental illness, a particularly vulnerable prisoner will be unable to tolerate isolated confinement even for a day). Dr. Grassian's list of psychiatric symptoms that regularly appear in relatively healthy individuals provides a clue to why prisoners prone to mental illness suffer breakdowns and despair. When an average individual who is placed in an environment develops massive free-floating anxiety, hyper-responsiveness, paranoid ideas, confusion, perceptual distortions, motor excitement and so forth, and becomes frightened he will not be able to control his aggressive fantasies, just imagine how difficult it would be for someone who is prone to paranoid psychosis or suicidal despair to remain balanced. Dr. Grassian's last reported psychiatric symptom, the rapid reduction of symptoms upon termination of isolation, may or may not occur – in my clinical experience, once an individual crosses a line into psychosis or depressive despair, it is very possible that removal from the harsh conditions of isolated confinement will not be sufficient to bring him or her back to a normal mental state.[42] I have reported my findings to courts (see Appendix A) and published my findings.[43]

C. My Findings from Interviews and Chart Reviews of Prisoners in Isolated Confinement in New York

My interviews with prisoners in New York DOCS entirely confirm this general understanding of what happens to prisoners prone to mental illness in isolated confinement. In prisoners with a history of or vulnerability to psychiatric breakdown, irrational thoughts and primitive, disorganized behaviors often emerge. Internal impulses linked with anger, fear, hopelessness and other strong emotions grow to overwhelming proportions.

Many, if not all, of the prisoners discussed previously in this Report, demonstrate this suffering. A prisoner who suffers from serious mental illness explained what happens to him in SHU:

W.S. **(Interviewed while housed in ICP at Great Meadow on 8/27/03).**

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[42] Once again, OMH officials have long recognized this problem. Richard Miraglia, Associate Commissioner of OMH Division of Forensic Services, testified in his deposition that he does not support the conclusion that the psychological effects of isolated confinement are short-term (Miraglia Tr. 132-133).

[43] Kupers, Terry, Prison Madness: The Mental Health Crisis and What We Must Do About It. San Francisco and New York: Jossey-Bass/Wiley, 1999.

History: This man had been in prison for five years and was planning for release in three months. He had been in ICP for one year. Before that, he had been in SHU for 90 days, and before that in GP. He went from SHU to CNYPC (five months) and then was transferred to ICP. In SHU, "I wasn't myself, I was real paranoid – after I got out I was OK. The voices were worse in SHU, I always thought people were talking to me." He was prescribed Lithium and Zyprexa. He cycled several times between SHU and observation before being sent to CNYPC. He said that in SHU he feels closed in, claustrophobic, and then he gets paranoid and angry. He likes ICP and does group therapy. He had been victimized as a "bug out" in General Population. He went to yard in ICP, but never did in SHU because he didn't trust the others.

Mental status examination: There was a thought disorder, flat affect, concreteness, and other signs consistent with a diagnosis of Schizophrenia.

Clinical chart: His chart corroborated the history he gave me.

Another prisoner with serious mental illness explained to me the effects of isolated confinement on him:

J. J. **. (Interviewed while housed in observation at Sing Sing on 5/7/03).**

History: This man had been in prison "off and on" for seven years, and was going home in 12 days. He had been at Arthurkill Correctional Facility, where he was put in "the Box" (SHU) and then transferred to "the Box" at Sing Sing. He had two psychiatric hospitalizations in the community, for a total of 18 months on psychiatric wards prior to incarceration. In spite of this history of pre-incarceration mental illness, he felt he was mentally stable in prison until he arrived at the Box, and then, as soon as the door to his cell was closed, "I began to feel the room was shrinking and I couldn't breathe." He described a panic attack. He said "I never felt claustrophobic before." As soon as "the hatch" of his Box cell was opened "I feel better!" He described worsening paranoia in the Box – "every noise seems loud" – he had been hearing voices previously, only partially controlled by medications, but he said "The voices became much worse as soon as I was put in the Box – I 'lost focus' – I couldn't concentrate on anything." Also, he experienced mounting rage and "I was afraid I wouldn't be able to control it." He told "the doctor" that he would have to hurt himself if left in the Box; the doctor talked to him about this at cell-front (never in the privacy of an office). When the doctor failed to return to see him, he put a sheet over his head – he proceeded to explain that he did not have a bag, and he figured he could treat his trouble

breathing during a panic attack with a sheet as a substitute for a bag (it is true that one of the ways to counter the hyperventilation of a panic attack is to breathe into a paper bag, but a sheet would not serve as a substitute).

Mental status examination: He talked very fast, reflecting pressured speech – there was a definite manic feel to his presentation. He seemed to have some thought disorder and concreteness.

Emotional harm is made even worse by sleep deprivation, and very many of the prisoners I interviewed in New York prisons report that on account of the noise, or due to increased agitation or anxiety they have suffered since being confined in SHU, they have suffered from severe insomnia. Loss of sleep intensifies psychiatric symptoms by interfering with the normal diurnal rhythm (the steady alternation of day and night that provides human beings with orientation as to time), and the resulting sleep loss creates fatigue and magnifies cognitive problems, memory deficits, confusion, anxiety, and sluggishness. In other words, prisoners vulnerable to psychiatric breakdown are more likely to suffer breakdowns in situations that cause sleep-deprivation, and many of the prisoners I interviewed told me that they have been having serious problems sleeping since being confined in SHU, and their sleep loss is associated with worsening psychiatric symptoms.

Another prisoner suffering from serious mental illness explained to me that his mental disorder was aggravated by isolated confinement, while at the same time he experienced other symptoms that were not part of his mental disorder prior to SHU confinement:

I.V. **(Interviewed while housed in SHU at Wende on 9/25/03).**

History: I.V. had been in prison for four years and in SHU since July, and he spent six months in SHU at an earlier time. He suffers from Bipolar Disorder and has attempted suicide on multiple occasions. He made several suicide attempts prior to incarceration and was admitted to Bellevue psychiatric ward and at least one other hospital, for depression plus auditory hallucinations – he heard his mother's voice telling him to kill himself. He was prescribed both anti-psychotic and antidepressant medications. His symptoms became much worse in "the Box." He made a suicide attempt in SHU, and he has received many tickets in SHU. He cannot read in SHU because of concentration problems, but out of SHU he is an avid reader. He had problems sleeping that are much worse in SHU. He described missed meals, showers and recreation because the correctional officer who announces them either does not call out that he is coming by or ignores him. When he gets depressed, which is especially likely in SHU, he gets into arguments with correctional officers. He described himself as a perfectionist, trying to explain why he cleaned his

cell four or five times per day while in SHU. He has been repeatedly admitted to observation and then sent back to SHU, with continuation of anti-psychotic and antidepressant medications.

Mental status examination: This examination is entirely consistent with a diagnosis of Mood Disorder with Psychosis.

The architecture and policies in the Special Housing Units (SHU) of the NY DOCS are designed to foster isolation and idleness. Sensory deprivation is not total – officers pass by to give out food trays, make rounds or perform "counts," and there is the intermittent slamming of doors and it seems from the prisoners' stories and my own observations that there is much loud yelling – but this kind of company and noise does not constitute meaningful human communication. And by design, there is a minimum of programming, almost no educational activities, little if any substance abuse treatment, and what is termed recreation amounts to little but a trip to a small fenced-in area where there is no athletic equipment. The recreation pens are very small, the prisoners are in a pen by themselves (an exception is Bedford Hills where the exercise can be congregate), there is no athletic equipment, and many prisoners told me it is not even worth going to recreation since there is nothing to do.

Many of the prisoners suffering from serious mental illness in SHU reported deterioration of their condition as soon as they were transferred to isolated confinement. There are many examples. Here is another:

CCZ. **(Interviewed while housed in SHU at Clinton on 7/15/03).**

History: This man was returned to prison on 7/25/00. He had been in general population at Attica and was taking psychiatric medications. Staff were fixing a toilet and found a "shank." He claims that they erroneously thought it was his; he was given a SHU term until 2007. He has many more disciplinary tickets, most of them received while he was in SHU. He was in the Attica SHU for 18 months with no time on the yard, he did the STP program but was "kicked out." He complained of claustrophobia, feels the world is against him, and told me when he gets angry he hears voices. He has been in psychiatric treatment since age 12, and was in a psychiatric hospital for evaluation during court proceedings. He has been prescribed Risperdal in spite of being given a diagnosis of Adjustment Disorder. He stated clearly that his paranoia increases in SHU. He told me he does not like to take psychiatric medications because the correctional officers "hassle" guys who take meds. He described a "breakdown" where he becomes confused when frightened about a cell extraction. He used to read when he was in GP, but he told me that in SHU he cannot comprehend what he reads.

Mental status examination: He seemed concrete, reported voices (giving some details) and exhibited ideas of reference and significant anxiety; there was some tangential thinking. It was difficult to assess paranoia because his claims about harassment by correctional officers might contain some reality – but he claimed people tamper with his mail and his thoughts. He is moderately positive for First Rank Symptoms, a very good indication of Schizophrenia.

D. Deterioration in Isolated Confinement is not limited to Prisoners with Psychosis and Severe Mood Disorders

The suffering and decompensation experienced in isolated confinement is not limited to prisoners with Schizophrenia, Major Depression or Bipolar Disorder. To cite one more example, the suffering of someone who is diagnosed Posttraumatic Stress Disorder – a condition with a high incidence in the DOCS population[44] – is made worse by isolated confinement. For many prisoners, the trauma of isolated confinement replicates earlier traumas. I will present one case of many I encountered, where the trauma of isolation replicated earlier traumas and thus greatly exacerbated Posttraumatic Stress Disorder and other mental illnesses:

N A. **(Interviewed while at Albion on 9/24/03).**

History: This woman was recently transferred out of SHU. She has been in prison for several years and should be released in February. As a girl, she was put in a closet as punishment. She suffers flashbacks, panic, startle and other post-traumatic symptoms, all much worse in SHU. She said OMH does not help her. She was taking no medications at the time of our meeting, but she had been taking Prozac, Depacote (mood stabilizer) and Celexa (antidepressant). She eventually refused the medications because they were given in too high a dose, causing side effects, and she was receiving no counseling. She came to Albion in July, 2002. She had a terrible time in SHU, "flipping out" with anxiety attacks; she felt closed in, paranoid, and ignored. She associated being in SHU with being in the closet as a girl. Her mother beat her and locked her in the closet. She was taken from her mother at 11.

In SHU, she cried a lot and had painful memories. And in SHU without medications, she got depressed and anxious, and became aggravated and

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[44] Terry Kupers, "Trauma and its Sequelae in Male Prisoners," American Journal of Orthopsychiatry, 66(2), 189-196, 1996; Angela Browne, Brenda Miller and Eugene Maguin, "Prevalence and Severity of Lifetime Physical and Sexual Victimization Among Incarcerated Women," Int'l Journal of Law and Psychiatry, 22,3-4,301-322, 1999. Dr. Donald Sawyer testified that between 40 and 60% of male prisoners in DOCS and an even higher percentage of women have histories of significant prior sexual and physical abuse (Sawyer Tr. 201-202).

got into fights, which led to tickets and more SHU time. She had migraine headaches in SHU. She tried to tell staff about the closet, but they didn't listen. She had flashbacks to abuse by her mother; in addition, she had nightmares, and she had phobias about rats and dogs biting her. She was better when taking Prozac 60 mg. She did not go to recreation when she was in SHU because she was afraid the officers would tear up her cell doing a search. She told me officers use searches to harass prisoners, and they subjected her cell to more searches because they knew she couldn't control her temper. She was hoping she could stay out of trouble for the short time left in her term so she could leave without doing more time in SHU.

Mental status examination: This very intense woman was obviously anxious and became more so as she talked about painful subjects; she also became sad. She presented a credible history of the intrusive and constrictive symptoms that are consistent with the clinical picture of Posttraumatic Stress Disorder.

Clinical chart: Her chart contained a history of pre-incarceration psychiatric hospitalization and diagnoses of Psychosis, Depression and Posttraumatic Stress Disorder.

Dr. Angela Browne, who interviewed OMH and Corrections staff at Bedford Hills Correctional Facility at the behest of Commissioner Goord and Superintendent Lord in the wake of a rise in self-harming conduct, expressed concern about isolation in SHU serving as a re-traumatization for women who had been repeatedly traumatized, both physically and sexually, prior to incarceration.[45]

E. The Disproportionate Number of Suicides in Isolated Confinement Demonstrates the Risks of Placing Prisoners with Serious Mental illness in Isolated Confinement

Suicide is a huge problem in isolated confinement – and despair, depression and thoughts and plans of suicide are widespread in NY DOCS' SHUs. OMH statistics for 1998 through 2000 (report of 6/4/02) reflect that in 1998 there were 14 suicides state-wide, five occurred in SHU and one in Keeplock. In the same time period 3% of prisoners were housed in SHU and 5% in Keeplock. Thus 36% of all the successful suicides in the entire department occurred within the 3% of prisoners confined in SHU. As it turns out, in other years there was even a greater disproportion of suicides in isolated confinement. 1999 figures reflect that 50% of suicides in the entire population occurring in the 8% of prisoners confined in SHU or Keeplock, and 25% of all suicides

[45] Angela Browne Report, 2002 (Pl. Ex. 111), p. 12; Superintendent Lord agreed that such re-traumatization may occur (Lord Tr. 109-111).

statewide occurred in the 4% of the population confined in SHU. In 2000, 43% of suicides in the entire corrections department occurred in the 4% of the population in SHU. Plaintiff's counsel in this case prepared a chart of suicides between 1995 and mid-2004, which demonstrates that in those years 53 of the 119 known suicides, or 45%, involved prisoners assigned to some form of isolated confinement.

Despair is bred by conditions of long-term isolated confinement, and this is a large part of the reason so many prisoners I interviewed in the SHUs suffer from severe depression and so many are suicidal. To mention just one factor among many, a prominent sign of serious depression is hopelessness. Hopelessness is bred when the end of an ordeal is not within view, and intensifies when the end of an ordeal becomes unimaginable. In isolated confinement units, depression is as prominent on the list of psychological symptoms as are anxiety, paranoia and rage.

But there is an additional aspect of isolated confinement in the NY DOCS that exacerbates depression: the indeterminancy of SHU terms. By policy and practice, there is no time limit to SHU confinement in NY DOCS. While there are some guidelines as to how much SHU time can be given for some infractions, hearing officers have large discretion in determining how much SHU time to issue. While each sentence to SHU, determined by a hearing officer, has a finite length to it, in practice, prisoners in SHU tend to receive more tickets after they arrive in SHU, and this lengthens their term in SHU, often with no end in sight. This is especially the case if the prisoner suffers from a serious mental illness. Prisoners with serious mental illness have more trouble than non-disturbed prisoners remaining in control of their tempers when they are in isolated confinement. The typical pattern is for them to get more than their usual number of tickets after they are consigned to SHU. The result is that many prisoners with SMI feel hopeless about ever getting out of SHU, which magnifies their despair. That despair is further magnified because the presence of disciplinary tickets has a negative influence on a prisoner's chances for parole. Many prisoners with serious mental illness told me that they truly believed they would never be released from SHU – because they would receive more tickets on account of behaviors they were incapable of controlling in SHU setting – and they told me that they would lose "good time" on account of being sentenced to SHU, and they did not think they would be granted parole. All of these factors exacerbate their sense of hopelessness and despair, and no doubt increase the risk of suicide.

I am quite troubled that in a study of suicide risk factors in NY DOCS by CNYPC,[46] there is hardly any mention of the fact that isolated confinement is a very significant risk factor for suicide. Whether one employs the OMH figure that 34% of successful suicides involve prisoners consigned to SHU or Keeplock, or the 45% figure that I believe is more accurate, isolated confinement is a very significant risk factor for suicide. But in their study of suicide risk factors, OMH officials list such risk factors as mental illness, history of past attempts, substance abuse, bad news, and "prison

[46] "Suicide Risk Factors in New York State Prisons." By Bruce Way, Richard Miraglia, Donald Sawyer, Richard Beer, and John Eddy, November 13, 2002.

stressors," but they do not discuss the effects of isolated confinement – even though in several of their depositions, these same officials testify that SHU confinement or isolated confinement exacerbate mental illness and despair.

It is not unusual to find a prisoner who received only occasional tickets prior to the one that landed him or her in SHU, but then, once in SHU, that same prisoner accumulates dozens of tickets, many of them Tier 3 tickets that result in an even longer SHU term. I have explained some of the reasons for this, including the mounting rage that tends to grow out of control in SHU, the deterioration of one's mental condition, and the often resulting repeated hostile interactions with staff. Prisoners are correct in their perception that serious mental illness makes it very difficult, if not impossible, to control one's temper and conform one's behavior to expectations in a SHU setting so that one can remain free of tickets and eventually gain release from isolated confinement. **The subjective sense many prisoners shared with me is a loss of all hope of ever leaving SHU. This kind of hopelessness adds to the despair and depression and drives many prisoners with serious mental illness in SHU to contemplate self-destruction, and then to act on their suicidal ideas.**

When prisoners sense that staff do not take their pain and despair seriously, but rather view them as "malingerers" or problem prisoners whose only mental illness is Antisocial Personality Disorder, they experience even more despair. It is no accident that as many as nearly half of suicides that occur in DOCS take place in isolated confinement, or involved prisoners who are serving a term in isolated confinement. Of course, the ultimate tragedy occurs when the despair becomes overwhelming for the prisoner, but over-concern about malingering or manipulations leads mental health staff to miss what would otherwise be clear signs of an impending suicide. When these two phenomena combine, a prisoner may succeed in ending his or her life. I have described many cases of prisoners with serious mental illness making suicide attempts and cycling from SHU to observation and CNYPC and then back to SHU. I will mention a few tragic cases where prisoners have succeeded in their attempt, and the death is clearly connected with isolated confinement. Of course, in these cases, I did not have an opportunity to interview the prisoner before his or her demise, and thus unlike in other cases presented in this report, I did not have an opportunity personally to take a history and I cannot provide my own mental status examination. I did review the clinical chart and/or I reviewed reports of investigations of the deaths.

R.W.

This 17 year old male had been admitted to Downstate Reception on 1/26/01, and he died by hanging in his isolated confinement cell on 3/16/01. Review of his clinical chart reveals he had a history of previous psychiatric hospitalizations (Benedictine Hospital in Kingston, NY) in the community since age 12 for behavior problems, for which he was prescribed anti-psychotic and mood-stabilizing medications. He grew up in

group homes and had a history of substance abuse. At Downstate he was on the OMH caseload and was assigned Mental Health Level 2. His diagnosis on 1/26/01 was Impulse Control Disorder NOS and Personality Disorder NOS. A core history on 1/26/01 notes allergy to Thorazine, denial of past suicidal behaviors, and anxiety about being in prison. The note recommends follow-up by a psychiatrist and supportive psychotherapy. As of 1/30/01 he was prescribed the anti-psychotic medication, Risperdal, 2 mg. per day. A Nursing Assessment on 2/6/01 notes depression, seizure disorder and head trauma, and provides this psychiatric history: "Psych. History since '95. Hospitalized a few times for clinical depression. Becomes 'explosive' when confronted with his issues." On 2/11/01 he is admitted to RCTP "Upset, crying and stressed out," per a call from the Block Officer. A statement by the patient of 2/22/01: "The MH services have been helpful but I have not been seen often. The medication does its job, but I need to talk about my problems, too." The treatment plan includes a 15 minute meeting with a nurse when medications are started and then monthly. On 2/12/01 the Risperdal was discontinued and he was prescribed the anti-anxiety agent, Atarax. He was placed in Keeplock in early February, and released on 3/9/01. He was receiving supportive psychotherapy and Atarax, and was to return to see the counselor a week from 3/9.

The NYS Commission of Correction Report of R.W.'s suicide (6/19/01) recommended that the prescription of Risperdal should have been continued until the prisoner was transferred to his destination facility – OMH, however, protested this would not be proper clinical practice. On the morning of his suicide, the prisoner was involved in an altercation with an officer and knew he was facing a sentence in Green Haven SHU as a result of it, a prospect which, according to the investigation of his suicide, terrified him. That morning he was escorted to a cell in the Mental Health Unit or Protective Custody area that was designated for punitive isolated confinement. A nurse saw him there and noted he had been crying – but the RN had 150 prisoners to see during morning rounds and admitted she knew nothing about this prisoner's clinical situation.

Because of R.W.'s young age (17), past history of psychiatric hospitalizations, prescription of anti-psychotic and mood-stabilizing medications, and anxiety and depression (noted in the clinical chart); because he was prescribed an anti-psychotic medication (Risperdal); because he had a history of head trauma and seizure disorder; because he required admission to observation a short time after entering DOCS, and because he had been involved in an altercation with an officer and knew he was

facing a term in SHU – for all these reasons, this young man should have had a far more thorough mental health assessment.[47]

In other words, someone should have been paying attention. The fact that nobody did pay attention displays a callous disregard on the part of OMH staff to the welfare of this seriously ill young man whose troubled psychiatric history and current instability was so apparent. This young man, who was in prison for less than two months, almost immediately found himself unable to comply with prison rules and ended up in isolated confinement. He should not have been placed in isolated confinement, and he should have been provided with more intensive mental health treatment (which he told OMH he needed) in a supportive environment such as an ICP. The diagnoses he was given, Impulse Control Disorder NOS and Personality Disorder NOS, do not capture the degree of anxiety and depression reflected in narrative progress notes contained in his clinical chart.

> Y.D. **, died by suicide in Keeplock in ICP at Bedford Hills on 9/22/00.** She had entered DOCS on 1/4/00. She had a long history of serious mental illness and suicide attempts, with many psychiatric hospital admissions, including at CNYPC during prior terms in DOCS. In fact, upon her release from DOCS following a prior term, she was committed to a psychiatric hospital. She had been diagnosed with Schizoaffective Disorder and was prescribed psychiatric medications. She had disciplinary problems, she was angry, and she was not entirely compliant with psychiatric treatment. Her clinical chart contains diagnoses of serious mental illness since 1994, when she was diagnosed Bipolar Disorder and treated with anti-psychotic and mood-stabilizing medications. She entered ICP on May 12, 2000. A 5/17/00 progress note reflects that she does not want to take the anti-psychotic, Haldol, because it does not help and it causes muscle stiffness. She was also noted to be "bothered by visions of her kidnapped son's face protruding from walls." She continued to be disruptive and to attempt self-harm, with admissions to observation followed by return to ICP. On 8/25/00 she was placed on Keeplock in ICP for failure to follow a direct order. **Conditions on Keeplock in ICP were comparable to conditions in SHU.** From 8/25/00 to 8/28/00, she was in observation and was threatening suicide by jumping from the sink in her observation cell, or by setting her cell on fire. She cycled between observation and ICP at least one or two more times.

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[47] The OMH Confidential Quality Assurance Document by Dr. Thomas Ryan notes a similar conclusion by the Incident Review Committee: "The Incident Review Committee suggested a review of the possibility of doing a clinical assessment on active patients post altercation" – OMHCNY 0060357. In my opinion, Dr. Ryan's recommendation should have become CNYPC outpatient policy, but of course it did not become policy, and it is my impression that such clinical assessments are not part of DOCS/OMH standard practice.

According to the NYS Commission of Correction's investigation, on 9/22/00, two female prisoners entered into a suicide pact and cut themselves with a razor. While staff were working on their wounds, Y.D. hung herself in her Keeplock cell in ICP. Superintendent Lord agreed during her testimony (see Lord Tr. 185-186) that in the two months leading up to her suicide, Y.D. had engaged in numerous self-injuries and suicidal conduct; she stabbed herself, tied a strip of cloth around her neck, tied paper around her neck, set herself on fire several times, and on 9/22/00, the day of her death, stated that she was going to "hang up."

The NYS Commission of Correction's review of this prisoner's suicide found: "OMH staff at the Bedford Hills Correctional Facility did not formulate an effective treatment plan for Y.D. Over a tumultuous clinical course at BHCF, Y.D. repeatedly was moved from one inadequate therapeutic setting to another without real achievable treatment goals. OMH staff failed to admit her to CNYPC for treatment within a hospital setting, what plan there was obviously did not modify her manipulative and self-harming behavior." A 2/5/01 letter from Miraglia to Lamy, a response by OMH to the SCOC's report on Y.D. suicide, includes the criticism that the SCOC finding that the settings were inadequate therapeutic settings for the patient "is a judgment which fails to recognize the complex features of Y.D. 's behavioral and clinical features and is unduly critical of the therapeutic program at BHCF which heretofore has effectively served the psychiatric needs of thousands of inmates. OMH's ICP and RCTP at BHCF are fully accredited by the Joint Commission of Healthcare Organizations and are recognized as national models for the delivery of psychiatric services to incarcerated women." There are further exchanges about what went wrong, and what plans are being made to improve treatment for difficult prisoners such as Y.D.

If one reads only the clinical chart and documents related to Y.D. 's suicide, it might seem fair to attribute her demise to "the complex features of Ms. Y.D. 's behavioral and clinical features." The problem for this reviewer is that the problems that appear in the management of this case are all too familiar from other cases I have reviewed in NY DOCS.

Thus, the dismissal of self-harming behaviors as manipulations, the failure to establish a well thought-out and effective therapeutic regimen for prisoners who are both "disturbed and disruptive," the utilization of isolated confinement (Keeplock in this case) to "manage" such troubled prisoners – all of these things are system-wide problems and not accidental contingencies in Y.D. 's case. Y.D. clearly needed more intensive mental health treatment, not punishment. Superintendent Lord testified that it

was her view that Y.D. needed to be in CNYPC; she characterized Y.D. course during her incarceration as "an example of ping-ponging"[48] (Lord Tr. 187-188). Thus, her death is instructive in terms of what is missing in the NY DOCS/OMH collaboration.

Furthermore, Mr. Miraglia's responding to the SCOC's criticism by citing JCAHO accreditation is beside the point, and does not respond to the criticisms of treatment in Y.D.'s case that were expressed by the SCOC. If a prisoner who previously suffered from serious mental illness is un-diagnosed and consigned to a housing unit that does not provide adequate mental health treatment for prisoners with the level of psychiatric pathology and disability that that prisoner truly evidences, there is nothing in the JCAHO accreditation site visits that would detect the substandard care.[49]

Y.K., died by suicide at age 21 in her cell in SHU at Bedford Hills Correctional Institution on Aug. 17, 2002.

Y.K. tied a bed sheet around her neck and strangled herself. Like Y.D., she had a long history of serious mental illness and psychiatric hospitalizations in the community. In Y.K.'s case, these dated from her early teens, with diagnoses Bipolar Disorder, Major Depressive Disorder and Borderline Personality Disorder. She entered DOCS in May, 1999, and had five admissions to CNYPC. She is frequently noted to be depressed, to bang her head, to repeatedly attempt to kill herself, usually by hanging, and to be disruptive. She was prescribed anti-psychotic and antidepressant medications. She had attempted to "hang-up" many times, including an attempt in SHU on 6/26/00 that led to a two month hospitalization at CNYPC. She had attempted suicide in SHU several times. She had been returned to Bedford Hills on January 29, 2002, after spending two months at CNYPC. At first she was in ICP, and then was transferred to SHU because of a ticket for setting fire to her cell. Meanwhile there were several admissions to observation with return to ICP or SHU. She attempted to hang-up, and was banging her head in her cell on 4/17/02, which led to another hospitalization at CNYPC. She was returned to SHU at Bedford Hills on 5/12/02. She went back and forth between ICP/Keeplock and SHU until she was transferred to SHU for the last time on 8/15/02, two days prior to her death. In her final days, she was "contracted" not to harm herself (the safety and efficacy of the notion of contracting not to harm oneself was questioned by the Commission of

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[48] Superintendent Lord had explained earlier that "ping-ponging" is the same as cycling, discussed throughout this Report (Lord Tr. 69-72).

[49] Ms. Y.D. suicide is also significant because of Comm. Goord's acknowledgment that disciplinary sanctions are ineffective for self-harming behavior and may even exacerbate that behavior (see Jan. 19, 2001 response to SCOC.)

Correction in their Summary Report about her death), and she was evidently sent to observation and then back to her SHU cell. There were notes in her clinical chart about her being manipulative; her diagnosis was Borderline Personality Disorder or Mood Disorder NOS.

There were many reports and memos after the demise of [redacted] discussing whether she actually intended to die, whether she should have been admitted for a long-term stay on the inpatient unit at CNYPC because of her history of repeated suicide attempts (recommended by SCOC, but DOCS and OMH disagreed), and whether she should have been returned to SHU when she was clearly depressed and had evidenced suicidal behavior so recently. The New York State Commission of Correction (Final Report), in its recommendations, wondered why [redacted] had been transferred to SHU instead of being re-admitted to the RCTP, "considering her self-injurious behaviors while being transferred to the facility SHU on the day of her terminal event." The Commission also questioned the practice of "contracting for safety," and recommended constant observation for suicidal prisoners in observation, and more training about suicide for security staff. In response to the Commission's report on [redacted] Commissioner Goord wrote (2/10/04) that DOCS already had procedures in place for suicide watch, officers were already being trained, and clinical decisions are the responsibility of OMH. Richard Miraglia responded for OMH (2/4/04), disagreeing with the Commission's recommendation that [redacted] should have been considered for long-term inpatient treatment; he also protested that she was doing fine in SHU the day of her death and there were no signs she might be self-destructive.

The response of Mr. Miraglia, the Associate Commissioner of Forensic Services, to the New York SCOC's Final Report, merely supports the short-sighted judgment of the clinicians and gives little hope that high-level administrators will learn the lessons of this kind of tragedy and will act to reform the mental health service delivery system. Similarly, Commissioner Goord's failure to implement procedures for constant observation in the Satellite Units ignores the risk that suicidal prisoners might slip through the cracks created by interval watches.

This contrasts sharply with the testimony of Superintendent Lord that she would have preferred that [redacted] like [redacted], be sent to CNYPC, which she agreed was a safer environment for [redacted] (Lord Tr. 195). Superintendent Lord further testified that had she not been away (on vacation) at Bedford Hills at the time, she would have tried to prevent [redacted]'s transfer back to SHU. (Lord Tr. 196).

In a 1/12/04 letter to NYS Commission of Correction Chairman Frederick Lamy, Bedford Hills Satellite Mental Health Unit Chief C. Subin and Associate Director of Operations M. Petrino outline a plan [redacted] allegedly made with a prisoner in a

neighboring cell to alert staff when she attempted to hang herself on 8/17/02. That other prisoner allegedly failed to alert staff, and her failure to do so leads Subin and Petrino to conclude: "This was an accident and she (Y.K.) had not intended to die." This is a clinically unsound speculation and a cynical response by OMH to the Commission's conclusions about the suicide of Y.K. .

Clinicians are welcome to offer speculative interpretations to a live patient in psychotherapy, where the patient is free to reject or amend the interpretation in the collaborative quest for profound psychological truths. But when the patient is deceased, it is all too easy for clinicians and administrators to concoct interpretations that serve to justify their action or inaction leading up to the death. Nobody really knows why Y.K. killed herself. We do know from the record that she was very depressed, that she was often overwhelmed by despair, and that she had made many serious suicide attempts prior to the one in which she was successful. To suggest that it can be known that her suicide was an accident is to negate the complexity and severity of her distress the day that she opted to end her life. It is as if Subin and Petrino are trying to use Y.K.'s tragic demise to prove their point that prisoners' self-harming behaviors are "merely manipulative." The statement by these OMH clinicians that Y.K.'s suicide was accidental is speculative, clinically unsound, and actually quite cynical. The statement also fails to acknowledge what OMH clinicians have known for a decade, and been reminded of repeatedly, that just because behavior is, in part, manipulative does not mean it will not lead to death by suicide.[50]

B.X. **hung himself in the Auburn SHU on 1/25/96.** He had been discharged from CNYPC with a diagnosis of psychotic disorder, but was returned to SHU. In SHU there were delays in his being seen by mental health staff; he was seen mostly at cell-front and his medications were discontinued. The SCOC raised the question whether he was being treated in a punitive fashion at the expense of receiving the acute mental health treatment his condition required.

D.D.H. **hung himself while on Keeplock status at Sing Sing on 11/21/96.** D.D.H. was known to experience auditory hallucinations and had a history of suicidal behavior. There were delays in his being seen by mental health staff, and he accumulated several disciplinary tickets. Two months prior to his death he set his cell on fire. He failed to keep several appointments with mental health staff, or appointments were postponed, in the period just prior to his suicide. The Commission recommended better tracking procedures for prisoners with serious mental illness who fail to keep OMH appointments, and the development of a procedure whereby prisoners on the OMH caseload who fail to keep appointments and receive disciplinary tickets are seen by mental health staff immediately.

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[50] See Elaine Lord's "The Prison Careers of Mentally Ill Women," (Pl Exh. 105, p. 368).

> A.S. **killed himself while in Keeplock at Attica on (B Block) on 5/15/01.** A.S. had been double-bunked at Orleans S-Block SHU, and had made a suicide plan and attempted to have his cellmate commit suicide with him. He had been admitted to he Satellite Unit at Attica on 4/6/01 because he seemed suicidal. He had just been discharged from Satellite Mental Health Unit observation on 4/12/01, returned to Orleans S-Block SHU, and then transferred to Attica on 4/18/01. There were no notes about discharge from the Satellite Unit; he was not on antidepressant medications but there was no note as to why not. He had just received news of an adverse decision by Parole Board.

A.S. 's suicide was not the first time that prisoners committed suicide after receiving adverse news. G.G.E. committed suicide at Elmira Correctional Facility in November, 1996, following the denial of his parole. C.D. committed suicide in May, 1999, in the SHU at Sullivan Correctional Facility the same day his parole was revoked. Yet it was not until several months after A.S.'s suicide in 2001 that OMH instituted a policy requiring DOCS to promptly notify OMH regarding prisoners who receive news of adverse determinations. Even then, the policy was only instituted regarding prisoners designated Mental Health Level 1 or Mental Health Level 2. This policy would not have identified or protected either A.S. nor G.G.E., who were both Mental Health Level 3 at the time of their suicides.

Attorneys for plaintiff chronologically listed suicides from 1995 through 2004 in a chart ("Prisoner Suicides 1995-2004") which summarized and quoted documents relevant to each incident. The chart does not summarize or review the clinical records for any of the patients listed. I reviewed the clinical charts of many of the successful suicides and reviewed NYSCOC reports and other documentation pertaining to some of the suicides. Although I did not review each document summarized in "Prisoner Suicides 1995-2004," for those documents listed that I did review, I found that the summaries and quoted language were accurate.

One finds among the cases of successful suicides examples of prisoners who were not diagnosed adequately or were "un-diagnosed" while incarcerated in DOCS, and then eventually proceeded to kill themselves. Residents of SHU are vastly overrepresented among successful suicides, as are individuals who have a very long sentence to serve in SHU. There are individuals who were discontinued from the OMH caseload even though they continued to suffer from serious mental illness. There are individuals who accumulated a large number of tickets while confined in SHU, and many of those tickets may well have been driven by their mental illness. There are individuals who cycled (or "ping-ponged") between SHU and observation and CNYPC and back to SHU. There are individuals who had been in ICP and were discharged on account of unacceptable behaviors. In fact, a snapshot summary of the stories of prisoners who successfully completed a suicide

attempt in NY DOCS between 1995 and 2004 would look very much like a snapshot of the prisoners I interviewed and have been describing in this report. I will discuss in Section VI the problems I discovered in the way Crisis Intervention and Suicide Prevention is done in NY DOCS.

It is tragic when a relatively young person who has spent much of his short adult life behind bars commits suicide and never has an opportunity to find out what life in the community as an adult might hold in store for him or her. We can debate whether someone who is daily terrorized by hallucinations in a prison cell is really suffering from a bona fide mental illness or is "merely malingering." And we can argue about whether an individual who cuts his wrists is making a true suicide attempt or merely a "gesture." But most significantly, the suicides of prisoners in NY DOCS between 1995 and 2004 show the same inadequacies in treatment and housing of prisoners with SMI that manifest themselves repeatedly in my inspections, interviews, and document reviews regarding current prisoners. These tragic deaths thus provide an accurate window onto the problems that plague DOCS and OMH. As set forth above, nearly 50% of successful suicides occur in isolated confinement or involve prisoners currently sentenced to isolated confinement, even while only 8% of DOCS prisoners are in isolated confinement. Obviously, there is something about isolated confinement that leads prisoners to take their own lives.

A large proportion of those who committed suicide were suffering from serious mental illness. The individuals who eventually killed themselves had experienced all the deficiencies in the mental health services within DOCS that I have summarized above, and that I will discuss further in Section VI. The fact that so many of the prisoners who succeeded at killing themselves had been repeatedly admitted to observation and CNYPC and then cycled back to SHU forces one to consider the problems inherent in that kind of cycling. Quite a few prisoners who committed suicide had been identified as manipulative by OMH, including J. GG.G., N.K., U.U, I.F., P.D., GGH, Y.D., Y.K., P.R., H.Y. and P.N. And the other problems under discussion in this report – the transfer of medium security prisoners to Satellite Mental Health Units in maximum security facilities and their eventual receipt of Tier 3 tickets and a SHU term; the failure of the disciplinary process to discern the part played by serious mental illness in ticketed infractions; the failure of OMH to treat the anxiety and depression that predictably attends a prisoner's receipt of bad news (such as receipt of a SHU sentence, a parole board denial), etc. – all these problems crop up repeatedly in the stories of successful suicides within DOCS. I will discuss appropriate interventions for suicidal prisoners in greater detail in Section VI. For now, the main point is that the problems that are identifiable in successful suicide cases are remarkably similar to the deficiencies I am pointing to in the delivery of mental health services within NY DOCS.

It should be noted that not all prisoners suffering from serious mental illness claim to be negatively affected by SHU confinement. For various reasons, a small number of

prisoners prefer isolated confinement to being placed in a general population situation. For example, there are prisoners who fear for their safety, and because they are convinced there is no effective protective custody unit at their security level, they purposely violate rules or get into a fight so they will be sent to punitive segregation and remain isolated from the prisoners they fear. Also, there are prisoners who prefer to be by themselves, and are willing to give up activities in order to have a cell by themselves. In my experience, the prisoners who adjust well to the conditions of isolated confinement units for any reason make up only a few percent of the prisoners confined in these units. Among the 183 prisoners I interviewed, I found five or six who say they do not mind being in SHU. But even this small group have a list of complaints, including the long delays it takes to see a mental health clinician and the short time the clinician spends with them. The vast majority of prisoners find the experience extremely traumatic and painful, and their clinical charts (as well as OMH clinicians' repeated acknowledgments) attest to the worsening of symptoms and decompensation in SHU.

As I explained in Section V., SMI individuals typically exhibit a waxing and waning course over a lifetime that includes periodic acute episodes alternating with periods of relative stability when they comply with treatment, including the proper medication regimen. Research shows that the longer an individual's acute psychotic or depressive episode is left untreated, the worse his prognosis. Research also shows that early detection of serious mental illness, removal of the individual suffering from mental illness from the noxious and traumatizing environment, and intensive comprehensive treatment greatly improve prognoses. Mental health clinicians in the community work hard to provide people vulnerable to SMI a sheltered and therapeutic environment, and the standards in correctional mental health require the same commitment. Clinicians are required to try their best to provide intensive treatment, including but not limited to medications, and to protect the individual from repeated traumas – all this in the hope of improving his or her condition and prognosis. Conversely, and tragically, if the individual is left in a situation that is extremely stressful and traumatic, the psychosis or depression worsens and the prognosis becomes more grave. (This is an underlying reason for the exclusion from isolated confinement of prisoners who suffer from serious mental illness in many correctional systems.)

If a prisoner suffering from psychosis is left to hallucinate and evolve a fixed delusion in his cell as he suffers harsh prison conditions such as obtain in SHU, and is denied adequate mental health treatment, then his condition is likely to deteriorate further until he reaches the point where he is laughing inappropriately, smearing feces, experiencing bizarre and fixed delusions, and exhibiting other signs of decompensation. Sadly, this is the plight of many prisoners I met in the NY DOCS.

VI. The Mental Health Treatment Programs in DOCS Facilities

A. Mental Health Care in General

There were 19,408 prisoners in DOCS when OMH began providing mental health services in 1977. Today, there are approximately 65,000 prisoners in NY DOCS , 71% of whom have substance abuse histories.[51] The inpatient psychiatric facility, CNYPC, has approximately 200 beds, a number that essentially has not changed since 1977. At any given time, a portion of these 200 beds are filled with prisoners from county jails. ICP has a capacity of 551 prisoners, including the AVP at Green Haven. STPs at Attica and Five Points contain 25 and 18 beds, respectively (these are beds located in SHU housing). Additionally, there are a total of 56 observation cells at 11 prisons (intended for short-term stays for prisoners in crisis or danger of self-harm). There were 7,250 active OMH cases in February, 2001; Richard Miraglia testified that there were approximately 8,000 prisoners on the caseload in early 2005.[52]

Since OMH began providing mental health services to prisoners in DOCS in 1977, the approach to services has gone through several changes. Currently the system of mental health services is described by OMH as a continuum of care providing comprehensive services equivalent to public mental health services available in the community. In published articles, OMH describes CNYPC as an inpatient acute psychiatric hospital with a 200 bed capacity, plus 11 Satellite Units in the maximum security institutions, which include Residential Crisis Treatment Programs (RCTPs). RCTP contains observation cells for very acute care and a dormitory for prisoners who are recovering from an acute crisis but are not yet ready to return to their regular housing unit. The Satellite Units provide mental health services to the Intermediate Care Programs (ICPs) (an equivalent program at Greenhaven is called the AVP), and outpatient services throughout DOCS, including services to inmates confined in Special Housing Units (SHU). In two maximum security prisons, Southport and Upstate, there are no Satellite Units. Instead, there are Mental Health Units which do not contain observation cells or dormitory beds. There are a few other programs scattered throughout the DOCS system that are not included in this list of system-wide programs, such as the APPU at Clinton, Special Needs Units (SNUs) at Sullivan and Wende and 99 Company at Wende. I will briefly comment about each component program, and then I will discuss some system-wide problem areas.

The Correctional Association of New York expressed concern about staff shortages and vacancies in OMH/DOCS:

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[51] See New York State Department of Correctional Services, "Identified substance abusers," 2001; and Hal Smith, Donald A. Sawyer & Bruce B. Way, "Central New York Psychiatric Center: An Approach to the Treatment of Co-Occurring Disorders in the New York State Correctional Mental Health System," Behavioral Sciences and the Law Behav. Sci. Law 20: 523–534, 2002.

[52] See OMH Annual Report for 2000 and Miraglia Deposition, p. 186.

> The majority of correctional and mental health administrators we interviewed reported that mental health units throughout the state prison system are understaffed and under-resourced, resulting in overburdened clinicians, untreated inmates and a revolving door of admissions to Central New York Psychiatric Center (CNYPC). Many mental health employees reported feeling overwhelmed by burgeoning caseloads and inadequate time to treat individuals with serious psychiatric disorders. 'I'm supposed to say that current staffing levels allow us to meet the needs of our patients, but the truth is, they don't,' a mental health unit chief told us.[53]

And staff shortages are reflected in many documents I reviewed, including, for example, a 7/22/04 letter from Cheryl Giroux, Director of Personnel, to Nicholas Vagianalis, Director of Classification and Compensation for NYS Department of Civil Service, where Ms. Giroux writes: "The Office of Mental Health (OMH) has been experiencing great difficulty in the recruitment of qualified psychiatrists at all its facilities, for years."[54] Repeatedly I discovered mention in Psychological Autopsies and the New York State Commission of Correction's "Final Reports" about prisoner deaths that staff shortages played a part in the suicide or death.

For example, A Psychological Autopsy regarding the death by hanging of U R on 8/11/01, Drs. Charles Ware and David Frey write under Recommendations: "2. To address the actual emotional and congitive issues with patients may be only minimally feasible given patient case load. Until trust is obtained by patients in a therapeutic relationship with staff we will not have access to their private thoughts and feelings. Consequent decisions by them to end their lives cannot be prevented when they are determined to do so. There must be continued efforts by staff to develop therapeutic relationships with patients despite possible problems imposed by resource limitations."[55] Or, in the case of R.T., who died on 5/20/01, and the cause of death had medical as well as mental health components, the Commission's Final Report includes the following among its recommendations: "To review the current medical staffing plan, specifically nursing and physician services, at the Elmira Reception/Correctional Facility. A health services staffing plan should assure a sufficient number of qualified health personnel are available to provide adequate evaluation and treatment consistent with acceptable community standards of practice."

The Correctional Association's findings and other documents match my own impressions in regard to a staff and resource shortage in OMH. Even more important than documentation is my direct observation that mental health staff are not spending adequate time with prisoners suffering from serious mental illness. Prisoners in SHU reported to me that OMH clinicians spend only a few minutes with them at cell-front, and

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[53] The Correctional Association of New York, "Mental Health in the House of Coorrections: A Study of Mental Health Care in New York State Prisons," June, 2004, p. 28.
[54] OMHCNY 087954-087959.
[55] OMHCNY 0060264

even in twice monthly private sessions (mandated by the SHU Plan of Improvement) clinicians might spend less than ten minutes with a prisoner with SMI in SHU.[56] The prisoners in observation at all the facilities I inspected reported that OMH staff spend a mere few minutes per day with them – and this is during their acute crises. There must be a serious staff and resource shortage if this little time is devoted to patients undergoing psychiatric crises.

As I mentioned in my discussion of the suicide of Y.D. (Section V.E.), the fact that the OMH program has received accreditation by the Joint Commission on the Accreditation of Health Care Organizations (JCAHO) does not eliminate nor ameliorate the presence of very serious problems in the mental health care delivery system. The JCAHO review process, by its nature, fails to take into account many of the problems at issue in this litigation.[57] For example, if a prisoner who previously suffered from serious mental illness is erroneously un-diagnosed and consigned to a housing unit that does not provide adequate mental health treatment, this huge and unacceptable gap in services would not be detected by the JCAHO on its accreditation site visits.[58]

The JCAHO standards are not specific to correctional settings. For example, there are no JCAHO standards that address isolated confinement in a correctional setting. Likewise, JCAHO does not consider adequately where a contact between mental health staff and a prisoner may have occurred, even if it was at cell-front within earshot of other prisoners and security staff. The fact that accreditation has been achieved does not in any way alter the deficiencies and unacceptable policies and practices I am outlining in this report.

B. Inpatient Psychiatric Unit at CNYPC

I did not visit CNYPC in connection with this litigation, but I have, in the past, conducted a staff-training at CNYPC, and I have reviewed policies and other documents describing CNYPC programs and practices. Also, a large number of the clinical files I reviewed contain admission evaluations, progress notes, nursing notes and discharge summaries from CNYPC. I have discussed the CNYPC program with Dr. Carl Fulwiler, who toured the facility on June 18 and 19, 2003, and who interviewed 24 prisoner/patients at CNYPC.

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[56] See also Takarla Carroll Deposition, p. 9; Ram Lall Deposition, pp. 40-41.

[57] See Deposition testimony of Jayne Van Bramer, pp. 186-188 and 191-193.

[58] Dr. Stuart Grassian states in his 10/7/99 Eng Site Visit 1, "Thus, the JCAHO process intrinsically has severe limitations on its applicability to SHU inmates – limitations which are in fact explicitly stated in the December 14, 1998 JCAHO report regarding CNYPC. For example, in regard to Psychiatric Satellite Units at the various New York State Correctional Facilities, the JCAHO report states explicitly that it will not review decisions to house SHU inmates in isolated mental observation cells on the Satellite Unit, rather than in dorm settings, because such decisions are justified by DOCS on the grounds of 'security'" (p. 52).

CNYPC serves as the inpatient unit for DOCS. Patients on civil commitments from outside DOCS are also confined there, including one ward for county jail inmates. Thus, the bed capacity available to DOCS is well below the approximately 200 bed capacity of the facility. OMH Director Hal Smith told Dr. Fulwiler that the average number of admissions to CNYPC is 850 per year, and the median length of stay is 43 days. All staff at the facility are OMH employees, and DOCS does not provide security. Admissions are involuntary and must be court-ordered. This means the bar is high for admission – the prisoner must, on account of a mental illness, be a danger to self or others. After a complete evaluation a treatment plan is established which includes medications, group therapy and psychosocial rehabilitation.

Following admission to CNYPC, that prisoner/patient, regardless of whether he or she was in isolated confinement in DOCS, is placed in a congregate setting and is free to enter and leave rooms and common areas. The assumption in DOCS is that prisoners in isolated confinement are incapable of behaving well enough to be released from a cell and to mix with others. This is one reason why prisoners from SHU are not housed in the dormitory in the Satellite Units, and the dormitories are underutilized. But at CNYPC these same prisoners are housed in a room with others, are permitted out of their room and are encouraged to participate in group activities and treatment meetings. This obvious contradiction brings into question the assumption in DOCS that prisoners in isolated confinement cannot be permitted congregate activities, and that in STP they need to be locked into "cages" to safely meet as a group (see below for further discussion of STP, Section VI.F).

At CNYPC, prisoners are provided a variety of services through the "Treatment Mall" including group therapy, psycho-education services such as education about their illness and about their treatment, and anger management. The goal is to provide patients with the skills they need to function in prison and in the community. Dr. Fulwiler found CNYPC to be a "clean and well-run" facility, and he reports: "Despite the fact that it serves the prison population it feels like a modern hospital. There are no bars or gates." Prisoners participate in conjugate activities in the day rooms and other areas. The rooms have regular doors, which are left open. Meals are served in dining rooms. There are seclusion rooms, for use in acute situations. There is an admission area, there are acute wards, and there are longer term wards and psychiatric rehabilitation services (such as occupational therapy and classes in stress management). Patients take part in 90 minute blocks of programs from the Treatment Mall each day, as well as 90 minutes of recreation.

CNYPC is accredited by the JCAHO, and is a quality psychiatric hospital. Still, as the inpatient component of the DOCS/OMH comprehensive mental health service system, there are problems with the inpatient psychiatric program at CNYPC.

The admission criteria for CNYPC are too stringent, given that it serves as the psychiatric inpatient facility for DOCS. A psychiatric hospital serves important functions

when modeled as part of a comprehensive community mental health program. Not all patients suffering from an acute psychotic episode or "breakdown" meet the criteria of danger to self/others for court-mandated civil commitment. It is often the case that an individual experiencing an acute psychotic or manic episode will need to be hospitalized voluntarily so that his or her condition can be properly diagnosed and the acute episode can be treated in a safe place where there is adequate staffing to provide safety and intensive treatment. Also, when clinicians in an outpatient or residential treatment setting are puzzled by an individual's clinical course or there are problems with a medication regimen, they might want to admit that individual to an inpatient psychiatry ward in order to adequately diagnose him or to adjust his medications. When admission to the inpatient ward is limited to those meeting civil commitment criteria, many patients in real need of psychiatric hospitalization are denied that critical level of care. As I have noted repeatedly and illustrated with case examples, the most obvious reflection of this problem in NY DOCS is that prisoners remain in observation cells too long in the Satellite Units or are returned to isolated confinement cells instead of being sent to CNYPC. **I discovered many prisoners in observation who warrant immediate admission to an inpatient psychiatric unit, but languish in observation. In observation cells located at the prisons, treatment is entirely inadequate for the severity of their psychiatric condition, and the conditions of confinement are harsh and punitive – in contrast to the much more humane and therapeutic conditions at CNYPC.**

Another problem is the severe shortage of beds at CNYPC. In spite of the huge expansion in the population of DOCS in the last thirty years and the rising proportion of that population suffering from serious mental illness, the bed capacity at CNYPC has remained approximately the same as it was when OMH began providing mental health services to DOCS in 1977. This means that there is a long wait to be transferred to CNYPC, even for patients suffering from acute episodes of psychosis or severe suicidal crises. Dr. Shimkunas states that the wait can be 30 to 45 days to have an acutely disturbed individual admitted to CNYPC (Shimkunas Deposition, p. 34). Many prisoners told me, independently, that OMH staff does not like to send prisoners from SHU to CNYPC. Instead OMH sends prisoners to observation when they are acutely disturbed or suicidal, and then the prisoners cycle back to SHU without ever being admitted to the psychiatric hospital (CNYPC). I include case reports about many prisoners who are thus "cycled" from SHU or Keeplock to observation and less frequently are sent to CNYPC, including N.D., N.P., B.W., A.M., J.Z., V.J., D.D.X., E.E.Z., B.B.I., I.V., and T.R.; and in Case Studies, Appendix D, include H.K., X.F., B.P., Z.K., R.X., A.L., Z.H., L.V., J.V., and D.D.Q.

There are also too few after-care options for patients being discharged from CNYPC. After a stay in a psychiatric hospital, patients usually require a period of time in some type of "step-down" program. In the community, there are halfway houses and other forms of supported residential programs. These programs are "step-down" from the

hospital level of care, or "half-way" between the hospital and independent living. They supply a modicum of safety and support as well as an intermediate level of mental health care, between inpatient and outpatient. Some patients require some kind of residential treatment on a very long-term basis. As I will point out in the section on ICPs, there are too few ICP-level slots in DOCS, and patients are too often discharged from ICP because of disciplinary problems.

I saw several situations involving prisoners who were admitted to CNYPC because of a psychotic breakdown or a suicide attempt and were facing a disciplinary hearing for a ticket that was issued during the psychotic episode or the suicide attempt. The result is that the individual who has been helped to resolve or transcend the acute psychotic episode or suicidal crisis while at CNYPC is then returned to SHU, where the stress can induce a repeat psychotic or suicidal crisis. This is the dynamic that drives much of the cycling between SHU and observation or CNYPC and back to SHU.

When clinicians at CNYPC recommend a certain housing and treatment location for a patient they are discharging, it is very important that their recommendation be followed, otherwise the therapeutic gains of hospitalization can be lost because the patient is sent to a stressful environment. I presented the case of D.N., where STP was recommended by CNYPC upon discharge from the hospital but the patient ended up in SHU without being admitted to the STP. I will present one more case where the discharge recommendation from CNYPC not to return the patient to SHU was not followed, resulting in steady unremitting psychiatric deterioration:

> E.J. **(Interviewed while housed in SHU at Great Meadow on 8/26/03.)**
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> **History:** When asked what it's like to be in SHU, E.J. stated: "I get my head busted open by correctional officers – mental health knows this and says I need more drugs." (He shows me his head with signs of recent bumps and lacerations.) "I can't take the solitude, and I'm getting abused by correctional officers." He has not taken any psychiatric medications since November because they were causing side effects. He has been admitted to CNYPC twice, and he has been in observation three or four times. In SHU, he gets extremely angry and can't control himself.
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> **Mental status examination:** This intense man stared as he talked, exhibiting flat affect and concreteness. There was delusional material and credible reports of recurring auditory hallucinations with no sign of internal preoccupation at the time of our interview.
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> **Clinical chart:** E.J. was admitted to CNYPC from 11/00 to 2/01, and again in 9/02. He came to Great Meadow from CNYPC in 11/02. Command hallucinations and suicide behavior were noted. He has been prescribed Depacote, Zyprexa, Risperdal, Zoloft and other psychiatric

> medications. His diagnosis has been Paranoid Schizophrenia or other forms of psychosis. A 2/9/01 note at discharge from CNYPC to Clinton reflects staff recommendation that he be sent to ICP and not returned to SHU. He was sent to RCTP awaiting a cell in ICP, but by 4/2/01, he was returned to SHU, contrary to discharge recommendation. By 7/01 he was back in observation. He was re-admitted to CNYPC (9/9/02 – 11/12/02) and on discharge again returned to SHU. A 1/30/03 OMH progress note reflects: "Again, this writer feels patient is becoming more agitated and paranoid. Speech is loud and pressured, restless in chair with many arm gestures. He will be referred to psychiatrist...." Dr. Faruki sees him on 7/3/03, finds him paranoid and agitated and recommends anti-psychotic medications. In spite of this record, he is discharged from the OMH caseload in 12/03.

There are numerous prisoners admitted to CNYPC, which requires certification by two psychiatrists that the individual is suffering from a mental illness severe enough to make him or her a danger to self or others, whose diagnoses are then downgraded while they are inpatients. Very often the downgrading or un-diagnosis is entirely inappropriate, since the individual has a long history of serious mental illness and prior hospitalizations, and will subsequently experience repeated breakdowns or suicidal crises. In many cases, after the individual is given a diagnosis at CNYPC that does not indicate a serious mental illness, a Behavior Management Plan is developed that recommends against subsequent re-admission to CNYPC. I will discuss this kind of un-diagnosis in the section on diagnostic problems, below. (See VI.G.2.)

There is also too little integrated treatment programming for individuals who are "dually diagnosed," i.e. who suffer from both serious mental illness and Substance Abuse. The staff at CNYPC rely too heavily on "twelve-step" programs – self-help substance abuse meetings modeled on Alcoholics Anonymous and other leaderless programs. Twelve step programs should be available to prisoners who choose to partake. But since such a large proportion of prisoners have substance abuse problems (70-90%), and since federal standards mandate intensive treatment for individuals who are dually diagnosed, there need to be more clinician-facilitated treatment options for prisoners suffering from both serious mental illness and Substance Abuse. The fact that so many of the prisoners suffering from serious mental illness will be returned to SHU or Keeplock after they are discharged from CNYPC, and that there are few if any substance abuse treatment programs available for prisoners in isolated confinement (for most of these prisoners cell study is not an adequate option – see Section V), makes this an even more critical problem.

C. Lack of Adequate Crisis Intervention/Suicide Prevention in Satellite Mental Health Programs

I toured the Satellite Units in ten maximum security facilities. They contain observation cells, dormitories, ICPs and outpatient services. I will discuss the ICPs (joint DOCS and OMH programs) and outpatient services in separate sections (See Section VI.D. and E., below). Here I will discuss the observation cells and dormitories.

1. The Observation Cells

According to a July – December, 2001 Report on "Observation Cell Usage" by Dr. Bruce Way, there are 56 observation cells in 11 prisons in NY. I inspected ten of the 11 prisons. The general design was similar in all the satellites. There is a row of observation cells. Some units contain three cells, some contain eight or more. The cells are practically bare except for a thin mat, which is usually on the floor. The prisoners are often naked except for a Ferguson (indestructible) gown. There are usually no bedclothes except for a Ferguson blanket, and the prisoner has no television, no radio, and few if any amenities such as pen and paper. The prisoner is usually laying on the mat, idle. The walls of the cells are bars, in most instances covered by a metal mesh material, or they are covered with a plexiglass material known as lexan. In the front of the cells there is a hallway where staff can pass or approach the cell, and in the rear there is another hallway with access to the cells. The lighting in most of the observation cell areas is very low. In some units there are windows across the hallway from the cells, or windows on a wall of the cells that cannot be opened by the prisoner. There is some variation in the architecture. The observation cells at Five Points are fairly representative of all the units I toured. They are inside the Infirmary (at other institutions the RCTP is a separate unit). The floor of the observation cells is concrete, the walls are bars covered by a strong transparent plexiglass or lexan material, and on other parts of the cell walls there is a metal mesh inside the bars. There were six observation cells in a row, sharing common walls, and all were occupied on the day of our tour.

At Elmira Correctional Facility there are three observation cells in the Satellite Unit. They have bare concrete floors, solid doors, and there are almost no amenities. The prisoners confined therein lay on a thin mat on the floor, some have no clothes and cover themselves with a Ferguson robe, and they have no bedclothes except a Ferguson blanket on the bare mat. Most of the prisoners are entirely idle with no amenities. They are fed in their cells and do not go out of their cell for recreation or for any programs. In fact, quite a few prisoners in observation are given a restrictive diet as punishment. (See DeVito Deposition, p. 108.) Usually, during my tours, there were little if any staff interactions with the prisoners in observation, and no kind words. It is my understanding the officers make rounds frequently (every fifteen minutes by policy). Clinical staff visit prisoners in observation at their cell-fronts at least daily or, in some facilities a committee of mental health staff meet with the prisoner on a daily basis for a brief time in a separate

room and evaluate the prisoner's course. At Elmira, the solid doors on the observation cells obstruct observation.

I found the observation regimen in the Satellite Units to be deficient in the sense that high risk patients need to be in a hospital setting where they can be observed by clinical staff, including constant observation where clinically indicated. When suicide risk is what led to the inmate's transfer to observation, the prisoner is kept in this setting until he or she professes he or she is no longer suicidal. Some prisoners are transferred from observation to the inpatient hospital, CNYPC. Often when prisoners return to an institution after being discharged from CNYPC, they re-enter the institution by being placed in observation or the dormitory. SHU prisoners are not generally housed in the dormitories, pursuant to DOCS policy. Many if not most of the prisoners are transferred after their stay in observation back to the unit from which they had arrived in observation, and for many prisoners I met that means a SHU or Keeplock cell.

Dr. Way ("Observation Cell Usage" December, 2001) reports that 23% of the observation cell admissions came from SHU (where, he reports, 12% of prisoners statewide were confined as of December, 2001); and 25% were discharged from observation to SHU. Further, Dr. Way reports that 69% of prisoners were admitted with "basic" amenities, meaning two mats and underwear, whereas only 52% of prisoners were discharged from observation with full amenities. Dr. Way writes: "A number of persons who stayed longer than clinically necessary were not restored to full amenities. Shouldn't full amenities be restored to all these clients?" (See my comments about recent policy changes regarding amenities in Section IX.)

2. Clinical Principles that should apply to Observation

There are well-established clinical guidelines for the assessment and treatment of individuals who have attempted suicide or seem intent upon taking their own life. First, a thorough assessment is indicated. If there are indicators of very serious suicide risk, for example severe depression, a past history of suicide attempts, a note indicating sincere intent to commit suicide or command hallucinations (voices) ordering the individual to take his own life, then the individual who seems to be at risk of suicide needs to be placed in a safe setting. In the community this usually means a psychiatric hospital, but in a prison an observation room might be adequate for a prisoner who does not pose a very serious risk – under specific conditions. A critical condition is that the stay in an observation cell be very brief (less than 24 hours or, depending on staffing considerations, 48 hours over a weekend).

In order to properly treat patients in observation, and not turn observation into another form of punitive isolated confinement, staff's approach must be therapeutic rather than punitive, the prisoner's dignity and privacy must be respected, and the mental health staff must take the time to gain the suicidal prisoner's trust and offer the intensity of treatment that is required in such an emergency. The main component of treatment with a suicidal individual is one-on-one personal, confidential therapeutic contact. A trusting

relationship must be established in order to foster disclosure on the suicidal individual's part about the inner sense of despair and hopelessness that is driving the prisoner to seriously consider taking his or her own life. Little or none of this occurs in the observation cells I inspected or in the accounts of observation I heard during my interviews.

Psychotropic medications might also play an important part in the treatment of a suicidal individual, especially where there is severe depression or psychosis that includes hallucinated voices commanding the individual to harm himself or herself, but there are many problems and complexities in their prescription. For example, the most often prescribed type of medication in suicidal crises – i.e. antidepressants – can take between two and four weeks to reach full effect, so they are not very useful in the acute situation. **Another crucial part of the treatment of individuals intent on taking their own life is for the clinician to figure out what stressors are driving him or her to this level of despair, and then attempt to help him or her change that situation so that those stressors will not drive him or her to another suicide attempt after the immediate treatment for the current suicide crisis has ended.** In a significant proportion of cases the individual must be referred to a hospital or crisis unit setting. Examples of this are when the suicide crisis is driven by serious mental illness and hallucinated voices are commanding the individual to kill himself, when the crisis cannot be quickly alleviated, or there is a high risk of self-harm.

According to Andre Ivanoff and Lindsay M. Hayes, national experts on suicide prevention in correctional settings:

> In determining the most appropriate housing location for a suicidal inmate, correctional officials (with concurrence from medical or mental health staff) often tend to physically isolate and sometimes restrain the individual. These responses might be more convenient for all staff, but they are detrimental to the inmate because the use of isolation escalates the inmate's sense of alienation and further removes the individual from proper staff supervision. To every extent possible, suicidal inmates should be housed in the general population, mental health unit, or medical infirmary, located close to staff. Further, removal of an inmate's clothing (excluding belts and shoelaces) and the use of physical restraints ... should be avoided whenever possible, and used only as a last resort when the inmate is physically engaging in self-destructive behavior. Handcuffs should never be used to restrain a suicidal inmate. Housing assignments should be based on the ability to maximize staff interaction with the inmate, avoiding assignments that heighten the depersonalizing aspects of incarceration.[59]

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[59] Andre Ivanoff and Lindsay M. Hayes, "Preventing, Managing, and Treating Suicidal Actions in High-Risk Offenders," Jail Suicide/Mental Health Update, Vol 11, No. 2, Summer, 2002, pp. 4-5.

These are principles that reflect a consensus in the mental health field. They are not being followed by OMH, and OMH's failure to follow these guidelines has contributed to the disproportionate number of suicides in isolated confinement which have occurred even after the risk of suicide has been identified.

OMH's Violation of Basic Guidelines and Principles for Suicide Prevention and Crisis Intervention:

The suicide prevention and intervention programs in the prisons I investigated violate at every turn the guidelines I have presented and the principles that Ivanoff and Hayes explicate. Prisoners are left in their observation cells for long periods, often with no clothes and in their observation cells they have minimal or no interaction with staff (hardly sufficient to establish a therapeutic relationship). The prisoners on observation have only daily brief cell-front contact with OMH staff, and perhaps a committee meeting that lasts several minutes, hardly sufficient to establish a therapeutic relationship. The conditions of confinement are excessively harsh – e.g. no recreation and few if any amenities. The prisoners languish in their observation cells, idle and isolated. Many prisoners report that conditions are much worse in observation than in SHU, and professional attention is not forthcoming. In fact, the "treatment" a prisoner receives after disclosing suicide ideation, on average, is more punitive than it is therapeutic. Disciplinary tickets are routinely given to prisoners for self-mutilation and other self-destructive behavior, or for behaviors that are related to the suicidal crisis in less direct ways. (Note: this problem, which I encountered frequently in my interviews, is minimally addressed with the settlement of the Anderson litigation. I do not yet have sufficient data to assess recent changes in terms of disciplinary tickets driven by mental illness. I do know that the DOCS regulations still provide that a prisoner can receive a disciplinary ticket for self-harm behaviors.) On the mental health charts there are many notations about feigned or malingered suicide attempts. An example:

> BBI. ____ **(Interviewed while housed in SHU at Great Meadow on 8/26/03.)**
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> **History:** BBI has been in prison for seven years. He stated he had been at CNYPC with a diagnosis of Schizophrenia and Claustrophobia. He has cycled back and forth between SHU and observation because he is convinced he is being poisoned. He hears voices and believes he dissociates. He has been in observation for as long as a month at a time. He averred delusions, nightmares and intense fear that he will be set up by staff and this will result in his being attacked. Last December he burned his cell in a serious suicide attempt. He was sent to observation for two days and then transferred back to SHU. When I ask why he is repeatedly transferred from SHU to observation and back to SHU, without being sent to CNYPC, he tells me it is because OMH staff don't believe him about being suicidal. Finally, in April, 2003, he was admitted to CNYPC. He

has been depressed all along, and thinks about suicide all the time. He was discharged from CNYPC, then spent a month in observation, and then on June 26 he was transferred to SHU at Great Meadow. He had a psychiatric history prior to incarceration. When he is "behind glass" it feels to him like someone is trying to smother him. He gets disciplinary tickets for "bodily harm" or destroying state property. He does not go to recreation because he is afraid "they (officers) will jump me."

Mental status examination: His mental status was consistent with his history. There was some bizarreness and delusional thinking. He was depressed with psychomotor retardation and anhedonia (a lack of pleasure in anything – a sign of depression).

Clinical chart: BBI 's chart includes a 5/2/03 diagnosis of Schizoaffective Disorder plus various diagnoses given on other dates, including Paranoid Personality Disorder, no diagnosis and ASPD. BBI's chart shows many admissions to satellite units, intermittent severe psychiatric symptoms and acting out. On 5/2/03 he was admitted from SHU to CNYPC, not eating, paranoid, thinking his food was poisoned. His diagnosis then was Depressive Disorder. He has been prescribed Neurontin, Seroquel, antidepressants and other medications. He was repeatedly admitted to observation during suicide crises, and was very rarely transferred to CNYPC. The fact that on several occasions his diagnosis was changed to "no diagnosis," or "Antisocial Personality Disorder" with no Axis I condition, serves to corroborate BBI 's report that OMH staff do not believe him about his symptoms and the extent of his despair.

Clearly this man's psychiatric condition deteriorates when he is in SHU, but when he is seen at cell-front or in observation, he is not diagnosed with a serious mental illness and is sent back to SHU. After many repeated observation admissions and recycling to SHU, he wound up at CNYPC where they diagnosed psychosis. Subsequently he is not sent to CNYPC when his condition deteriorates, rather he is cycled between SHU and observation, sometimes remaining in observation for extended periods without being admitted to CNYPC in spite of his acute breakdown.

In reality, when a person contemplates suicide, he has mixed feelings about actually ending his life. Often he is merely too depressed and hopeless to be able to imagine continuing in life. If one meets a suicidal patient on a psychiatric hospital ward and asks "Do you think you are actually going to kill yourself?" or "Are you feeling imminently suicidal right this moment?" the response is very likely to be that he or she is not actually feeling a strong impulse toward self-destruction just now. But this does not necessarily mean it is time to discharge him from the hospital. Later, after the day-shift leaves, that same individual might lay in bed feeling overwhelmed anew by depression

and might then begin planning a serious suicide attempt. In other words, suicidal despair is rarely constant, and there are moments between profound lows in mood where a suicidal individual might even appear cheerful. In fact, we know from very tragic experiences in psychiatric hospitals in the community that individuals who were ambivalent about killing themselves until recently, but who have now decided definitely to take their own life, are very likely to appear to staff to be positive and not very depressed. Their resolve to take their own life momentarily trumps their depression, and they have a renewed interest in pursuing a purposeful plan, i.e. their self-destruction.

Consider the case where, at some point during the time when a depressed individual is equivocating between a decision to take his own life and a new resolve to go on, the psychiatrist asks him if he is actually going to kill himself, and he responds "No, I think I was just bottoming out and needed someone to talk to about the mess my life has become." What if, at that point, the psychiatrist accuses him of having "malingered" the entire suicide crisis or "manipulated" the staff into thinking he wanted to kill himself? The effect of the psychiatrist's punishing approach would not be therapeutic at all. But in fact, this is very often the scenario that is enacted in DOCS during prisoners' suicide crises. Another case is illustrative.

>] Z.H. **. (Interviewed while housed in SHU at Albion on 9/24/03.)**
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> **History:** Z.H. as been in prison for three years, and has spent over eleven months in SHU on separate occasions. She insisted that the officers treat prisoners suffering from mental illness worse than they treat the others in SHU. She said she is not at all assaultive. She has been in observation three times, on account of worsening depression and wanting to hurt herself, and each time she went to observation from SHU and then was returned to SHU, never being admitted to CNYPC. She reported she currently is prescribed Seroquel and Neurontin. She has never been admitted to CNYPC. She has been in psychiatric hospitals in the community, and spent six or seven years (between ages 23 and 29) involuntarily committed to a psychiatric hospital. Her current SHU term was to end a few days prior to her release from prison.
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> **Mental status examination:** Z.H. was obviously quite sad and cried openly during our interview. She was intermittently agitated and emotional, she talked fast, and seemed quite dysfunctional. She reported auditory hallucinations since age five, when she was raped. She credibly described voices that appear frequently and order her to kill herself: "Kill, kill, kill!" She insisted, very genuinely and poignantly, that she is "not a bad person."
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> **Clinical chart:** Z.H.'s chart reflects that she has spent time at Bedford Hills. She has a diagnosis of Major Depressive Disorder, Recurrent, with

> Psychotic Features (3/8/01), Psychotic Disorder NOS (3/10/03), and Posttraumatic Stress Disorder and Bipolar Disorder (9/4/03). She has been prescribed Seroquel, 400 mg., Zoloft 50 mg. and Neurontin 800 mg. A 3/3/03 note reflects "increase of psychotic symptoms on satellite – will adjust meds." She has been admitted to observation while acutely suicidal on several occasions, and then returned to SHU.

The problem with punitive and harsh conditions of confinement (for example lengthy stays in observation cells without amenities) and disciplinary write-ups for prisoners who attempt suicide is that these measures do not alleviate the prisoner's despair; indeed, they reinforce it. As soon as he or she is released from restraint, his condition may deteriorate further, or he might plan an even more lethal attempt. Meanwhile, the already suicidal prisoner is very likely to turn on himself the anger he feels on account of what he considers unfair and brutal treatment, for example a ticket for attempting suicide or very harsh conditions and deprivations in an observation cell. A clinician cannot punish a prisoner into transcending his or her despair. In fact, the prisoner knows that in order to get out of observation he or she needs to convince the mental health staff that he or she is no longer suicidal, so when the mental health staff member makes rounds and asks at cell front if the prisoner/patient still wants to take his or her own life, or when the staff committee calls him in for a very brief conference about his condition, he is inclined to answer that he is no longer planning or desiring to kill himself. Then, back in his cell, he can make another attempt.

Quite a few prisoners told me that they do not tell the staff when they feel suicidal, because they know they will be placed in observation, possibly naked, and they will essentially be punished even more severely for admitting they are suicidal. It is astonishing to find many prisoners in observation who report that the conditions are so noxious in observation that they would prefer to be returned to their SHU cell – and these same prisoners tell me that they had become suicidal only after finding life to be intolerable in SHU. The end result is that many prisoners who are feeling suicidal opt not to seek help from mental health staff and not to report such feelings, and this dynamic contributes to the high incidence of suicide in isolated confinement within DOCS.

Prisoners who exhibit suicidal behaviors or express suicidal ideas are very likely sent to observation in the Satellite Unit. From there, they might be sent back to their unit and then, when another suicidal crisis occurs, be transferred to an observation cell again. In other words, they cycle from their cell to observation and back, until the mental health staff decide this prisoner is too serious about committing suicide, or too depressed or psychotic, to be retained in SHU, ICP or the general population. Then he or she may be transferred to CNYPC. But if the prisoner who has recently been through a suicide crisis is transferred from CNYPC back to SHU, essentially the same kind of cycling is going on. I interviewed and reviewed the clinical charts of many prisoners who cycled repeatedly between SHU and observation in the OMH Satellite Mental Health Unit, with

occasional transfers to CNYPC and back again to the same SHU. I will illustrate the pattern with two cases:

B.P. **(Interviewed while housed in SHU at Great Meadow on 8/26/03.)**

History: This man has been in SHU for over a year, and will go home by the end of 2003. The ticket that had him transferred from Keeplock to SHU was written when he threw urine at another prisoner who had thrown excrement at him. He has been repeatedly suicidal in response to command hallucinations – he cuts, and displays scars on his neck and arms. He often hears his dead brother's voice telling him to cut himself. He was in the hospital one week ago for swallowing Ajax. He was depressed and hearing voices, and he was prescribed antidepressants. He has been in some form of psychiatric treatment since 1989, when he jumped out of a second story window with a noose around his neck in a serious suicide attempt. He was declared incompetent prior to trial, but then he pled guilty. In his SHU cell he mostly sits and stares, and often does not eat. He has been to observation a lot, often due to overdose or hanging attempts.

Mental status examination: This man displayed flat affect, depressed mood, hopelessness and helplessness. He made no eye contact. He gave credible reports of command hallucinations and exhibited bizarre thoughts. He was concrete with some cognitive blunting. There was strong suicide ideation and intention. This presentation is consistent with depression with psychosis, and suggests a high risk for suicide.

Chart review: Many psychiatric hospitalizations in the community are documented. He has been prescribed Zyprexa, Prozac, Neurontin, Paxil, Benadryl, Vistaril and other medications, usually an anti-psychotic or mood stabilizing medication plus an antidepressant. He is seen in SHU by psychiatrist Dr. Faruki, mostly cell-side, between admissions to observation – and cycles from SHU to observation and back to SHU frequently.

B.P., clearly severely depressed and psychotic, with command hallucinations telling him to kill himself. Yet he is left in SHU and never even sent to CNYPC for thorough evaluation. He cycles repeatedly from SHU to observation as he repeatedly tries to kill himself. OMH and DOCS have done nothing to alleviate the risk of harm to this patient; indeed, in spite of their knowledge of the risks, they have continued to maintain B.P. in isolated confinement, where he has attempted suicide many times, and have failed to adequately treat his depression in a therapeutic setting.

V.W. **(Interviewed while housed in SHU [STP Program] at Five Points on 3/13/03.)**

History: V.W. has been in prison for 12 years and in SHU for four years. He has been in STP for 15 months, and expects to be released from SHU in 2008. He has been prescribed Seroquel, Zoloft and Vistaril, he reports all in relatively high doses since his last ticket. He resents that the psychiatrist in SHU and in observation see him only at cell-front, so "you have to broadcast your problems." He also complains that the mental health staff talk to him or about him in front of correctional officers. He does not trust his therapist because of this breach in confidentiality. He cries and has flashbacks at the anniversary of his crime.

Mental status examination: This man was very anxious, he talked obsessively about side effects of the medications he was taking, he was not well-oriented regarding time, and he told me his disorientation adds to his confusion in SHU.

Clinical chart: The chart is quite thick. With no pre-incarceration psychiatric history, he attempted suicide at Rikers Island. He was sent to SHU in 2000. He has been prescribed strong dosages of anti-psychotic, antidepressant and mood-stabilizing medications for quite some time. His Diagnosis is Depressive Disorder NOS. He is admitted to observation repeatedly for suicidal ideation and intention, and then returned to SHU.

This man is repeatedly suicidal in SHU, even when he has participated in the STP while housed in SHU, is not admitted to CNYPC except once for a few days, is treated with anti-psychotic and antidepressant and mood-stabilizing medications and cycles very often to observation, where he remains for days or weeks and is seen only at cell-front and then returned to SHU with or without the STP.

Either because there are not enough beds at CNYPC, or because OMH clinicians often prefer to keep prisoners from SHU in observation for lengthy stays rather than transferring them to CNYPC, quite a few prisoners repeatedly cycle between SHU and observation and back to SHU. I will briefly mention another illustrative case. **Notice that this prisoner is one of many individuals who prefer a SHU cell to an observation cell. This speaks to the harshness of conditions in observation, one of the reasons I have concluded that observation is designed as punishment rather than as treatment.** Another reason I have concluded that observation is more punitive than therapeutic is the lack of meaningful therapeutic contact with OMH staff while patients are in observation – a few minutes of contact per day at cell-front or in a staff conference is not what I would call adequate clinical contact. No wonder so many prisoners feel that conditions in observation are so dreadful that they prefer SHU to observation, even when SHU is "pretty awful":

N.E. **(Interviewed while housed in SHU at Wende on 9/22/03.)**

History: This young man has been in prison for three years. He has been in SHU for four months, and prior to that did four months in Keeplock. He has had 20 or 30 tickets, many accrued while he was in "the Box." He is diagnosed Depression and ADHD, and is prescribed Wellbutrin. He has never been to CNYPC. He was in observation for 22 days recently. He prefers SHU to observation, where there is nothing to do, not even recreation. He feels worse in observation than in SHU, and cut his wrist in observation.

Mental status examination: This young man was obviously depressed, with downward gaze and psychomotor retardation. He reported hearing voices and obsessed about "hanging up." He told me he is hesitant to tell mental health staff about his emotional problems because he fears they will take advantage of them. He is saddened by what he perceives as a loss of intelligence while in SHU.

Clinical chart: His chart is eight inches thick. He is diagnosed Bipolar Disorder II (hypo-manic rather than manic swings alternate with depression – in other words, the "highs" are not as high as in mania). He has a history of depression and ADHD/Conduct Disorder from childhood. He cycles from SHU to observation and back on account of self-harm. Medications include Wellbutrin, Remeron and Depacote. A CNYPC inpatient screening note on 10/23/03 diagnoses R/O Adjustment Disorder with substance abuse and ASPD. An 11/5/03 psychiatric consultation continues the "no SMI diagnosis on Axis I" and recommends Seroquel or Zyprexa for behavior problems. But the commitment notes from psychiatrists admitting him to CNYPC after he "hung up" and nearly died all reflect serious Depression.

In summary, prisoners who report suicidal crises are treated in a fashion that is more punitive than therapeutic. It is likely that this contributes to the high incidence of suicide. Conditions in observation cells are unnecessarily harsh, the prisoner is left idle and isolated, sometimes for extended periods, and there is little or nothing in way of actual treatment except observation, medications usually prescribed by a psychiatrist visiting briefly with the patient at cell side, and daily very brief meetings with a clinician at cell side or with a treatment team in an office. Whether or not this is the intention of staff, the overall effect of this punitive regimen in many cases is to coerce the prisoner into falsely claiming that he is no longer suicidal so he can be transferred out of the harsh environment in observation. The fact that so many prisoners told me they prefer their SHU cell to the observation cell reflects the harshness of what should be a therapeutic program. A comparison between the stark deprivation and inattention that prevails in Satellite Unit observation cells with the humane and very decent treatment patients receive at the inpatient hospital, CNYPC, tells the whole story.

3. Underutilization of Dormitories

The dormitories in the Satellite Units I toured in 10 facilities, for the most part, are empty or grossly under-utilized. For example, when I toured Sing Sing on 5/7/03, there were three patients in a dormitory that has a capacity of 16. In a few facilities we came upon one or two prisoners who were being housed in a dormitory with six or eight beds. Dormitories in other institutions I toured were entirely empty. OMH reports 14 % occupancy for dormitory beds, system-wide, compared with 69% to 79% occupancy rates for observation cells.[60] This seems a waste of desperately needed beds in Satellite Treatment Units. I asked OMH staff repeatedly why the dormitories were so vastly under-utilized, and they explained that most of the prisoners who are in observation were transferred from SHU and still have a term to serve in SHU. DOCS does not permit OMH to house SHU-designated prisoners in a non-isolation setting, so they cannot be placed in the dormitories.

Something is terribly amiss here. Many of these same prisoners have just returned from CNYPC, or they may soon go to CNYPC, and at the hospital they will be in a room with an unlocked door and they will be taking part in group activities. Yet just before they go or as soon as they re-enter DOCS through the Satellite Unit they are suddenly not capable of being housed with other prisoners? This under-utilization of dormitory beds must contribute to an over-reliance on observation cells. In other words, there needs to be another form of confinement in the Satellite Units for prisoners from SHU who need crisis intervention services. Not everyone who is in crisis needs to be placed in observation. When individuals experience an acute psychotic breakdown or a manic episode, they need intensive mental health treatment but they may not require as close observation as someone who is at high risk of self-harm. Why should a prisoner who is suffering an acute psychotic breakdown be subjected to the deprivations of observation?

4. Lengthy Stays in Observation, Failure to Admit to CNYPC

Finally, whether the prisoner presents a high risk of suicide or is suffering an acute psychotic breakdown, he or she should not remain in observation, or even in the dormitory, for an extended period. The standard of care in the community dictates that stays in crisis intervention settings be very short-term. The purpose of the crisis intervention unit is to provide rigorous assessment and very short-term intensive treatment. Most such units in the community have a 24-hour limit. The patient can either be assessed and it can be determined within 24 hours that he or she does not pose a risk of self-harm, or where there is another kind of crisis such as an impending psychotic breakdown it can be managed with rapid medication treatment and the patient can be returned to a stable state within 24 hours, or else the patient needs to be admitted to the psychiatric hospital for further assessment and more intensive treatment. Crisis

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[60] Bruce Way and Robin Nash, "Mental Health Crisis Observation Cell and Dormitory Bed Usage," July 2001 – June, 2002.

intervention units are not designed for prolonged stays, and it is cruel to keep a patient deprived of amenities and activities for longer than it takes to make a rapid assessment or accomplish a rapid treatment. In practice, many patients in the community can be returned to their homes safely after they are assessed and treated in a crisis intervention unit for less than 24 hours, and the smaller number of patients who cannot be stabilized in that time frame can then be admitted to the hospital. The crisis intervention unit thus cuts down on hospital admissions by screening out the patients who can be treated in a short time and returned home. Of course, in NY DOCS, many of these prisoners arrived in observation from isolated confinement, and it is not acceptable to return them to an environment as stressful as isolated confinement (in contrast to returning a patient home in the community) immediately after they have suffered a crisis.

In his July–December, 2001 Report, "Observation Cell Usage," Dr. Bruce Way reported that the median length of stay in observation was three days in July and four days in the other five months of data collection. Dr. Way writes: "Reasons for higher median lengths of stay need to be explored, and, if applicable, corrective actions taken..." In a subsequent, July 2001 to June 2002 study of bed usage by Bruce Way and Robin Nash, they report an average length of stay in observation of four days, with variations between institutions, including a greater than six day average (in contrast to the median length of stay cited in the July-December, 20001 report) stay at Sullivan and a three day average length of stay at Great Meadow and Bedford Hills. These average lengths of stay are far too long. And why has OMH not heeded Dr. Way's statement in the earlier cell usage report, that "reasons for higher median lengths of stay need to be explored and corrective action taken"? A six day average means that approximately half the patients admitted to observation remain there for more than six days. And what these averages fail to reflect is that quite a few prisoners are admitted and discharged from observation in less than 24 hours, so there are a significant number who remain much longer than the three or six day recorded average. **I encountered prisoners who were retained in observation for weeks or even months, without amenities – and that means they had no clothes except a Ferguson gown, no bedding except a Ferguson blanket, almost no possessions, no recreation, and almost no social contact and no real face-to-face psychotherapy. This is entirely unacceptable by all standards; it constitutes harsh punishment and in most cases is not therapeutic at all, but rather worsens the patient's condition.** Another case will illustrate the point:

> Y.N. **. (Interviewed while housed in observation at Wende on 9/22/03.)**
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> **History:** Y.N. has been in prison for nine years. He was placed in observation 28 days ago because he cuts himself. He showed me scars on his arms. He has been at CNYPC four times, he was depressed and heard voices (his mother saying bad things since approximately age 12), and he was hearing voices commanding him to cut himself 28 days ago. He has been in SHU for seven years with multiple admissions (approximately ten)

to observation and four to CNYPC. He described mounting anxiety which was relieved by cutting and by seeing his blood, and he calmed down. He reported that in observation he has remained naked except a blanket and gown, the cell lights have stayed on all the time, and he has only been interviewed by mental health staff three times in the entire 28 days. He was put on loaf in observation without receiving a ticket – he was told he would receive the ticket after he gets out of observation. He told me staff make rounds at cell-front, but he does not want to talk under those conditions and merely says "I'm OK."

Mental status examination: This man had a gross tremor (involuntary movement). He was depressed with psychomotor retardation and gave a credible history of hallucinations. He told me he cannot read or write, and this makes his time in SHU more difficult to bear.

Clinical chart: His chart reflects admissions to CNYPC (core history 10/24/01), danger to self, and visual and auditory hallucinations including commands from grandmother. There are many notes in the chart about depression, command hallucinations and self-harm. He has been admitted to observation repeatedly for self-harm. He had a psychological assessment by Dr. John Wilson and a Behavior Management Plan dated 6/28/02. The plan recommended such things as delaying visits with psychotherapist after he attempts self-harm, returning him to SHU when medically cleared after self-harm, etc. He was discharged with a diagnosis of ASPD (primary), borderline intellectual functioning, substance abuse and old closed head injury (no neurological or neuropsychological assessment is reflected in the chart). There were subsequent admissions to observation and to CNYPC for continuing self-harm and depression, and, in spite of having been un-diagnosed, he continued to be prescribed Depakote 1,500 mg. bid, Seroquel 900 mg. per day and Zoloft 300 mg./day (hardly a medication regimen for a non-depressed, non-psychotic individual). But then a 10/8/03 progress note, evidently by a psychiatrist, reflected a diagnosis of Major Depressive Disorder with ASPD and borderline intellectual function – and the same medications.

Y.N. clearly depressed and likely psychotic, even as he is manipulative and disruptive, and he has spent a long time in SHU with very detrimental effects. He has been to observation many times for self-harm, and when I met him he had been in observation for 28 days. He is "un-diagnosed," and yet he continues to receive strong anti-psychotic and antidepressant and mood-stabilizing medications. But clearly his long stay in observation, while punitive, has not been therapeutic.

D. Intermediate Care Programs (ICP)

The Intermediate Care Programs (and AVP at Green Haven) provide a very important component of the comprehensive mental health treatment program within NY DOCS. Essentially, they are "stepdown" units. They provide less intensive supervision and treatment then the psychiatric hospital (and thus staffing is less expensive), but they provide more intensive mental health treatment than are available through outpatient services in the general population or isolated confinement units. The OMH studies of ICP programs correctly point out that programming is uneven at the various institutions – some ICPs provide more activities and treatment than others. I noticed quite a lot of idleness on the part of prisoners in the ICPs during my tours. I support the plan to make the ICP programs more even from institution to institution, and to enhance the programming and diminish the idleness.

In spite of problems, the ICPs (and AVP) are good programs and constitute an essential component of mental health services. Many more slots in ICP are needed, however. The relative shortage of ICP slots means that many prisoners with serious mental illness are not able to benefit from this "stepdown" component program. One of the ways that DOCS and OMH seem to justify their failure to provide intermediate care programming to very prisoners whose mental illness and disability require that level of care is to expel a significant number of prisoners deemed to have behavior problems. This does not make sense, clinically. Mental illness is a disorder of behavior, among other things. So how can a mental health system deny individuals suffering from mental illness the services they need by citing their inappropriate behavior as a reason for the denial?

In other Sections of this report I cite case after case of prisoners with serious mental illness being discharged from ICP, even though they require a mental health program of this level of intensity and longevity (i.e. ICP is the right program for them), because they are given a disciplinary ticket. Here I will cite three cases of prisoners with serious mental illness who have had the experience of landing in SHU, deteriorating in SHU, receiving more tickets, possibly cycling to observation or CNYPC and back to SHU, and then eventually being transferred to ICP, or returning to ICP, where their mental health stabilized. The fact that they were eventually able to re-compensate or stabilize, benefit from the ICP treatment program, and remain stable in ICP speaks to the need to keep prisoners with this kind of serious mental illness out of isolated confinement, and the need to provide them with the kind of treatment and relative safety that is available in ICP. Of course, to do this, OMH would have to develop many more slots in ICP – and if there were sufficient capacity in ICP, maybe there would not need to be as many prisoners discharged for disciplinary reasons. Here is an example of a prisoner who did poorly in DOCS until he was transferred into ICP.

M.N. **. (Interviewed while housed in ICP at Elmira on 3/11/03.)**

History: M.N. has been in prison for six years. He seemed intellectually quite impaired, and when asked what changes he would like to see in DOCS and OMH, he said "better chips in commissary." He was in SHU for six months at Sing Sing, and then transferred to ICP. He told me he gets mental health help because he hears voices. He has been to CNYPC once, and did well on Haldol – but he reported he is "OK" without medications now.

Mental status examination: M.N. did not look at the interviewer. He seemed quite impaired in cognitive functioning, had impaired intellectual functioning, exhibited signs and symptoms of psychosis, and seemed to be managing currently in ICP.

Clinical chart: The chart documents Delusional Disorder and Mental Retardation. Voices were reported. He had been cycling repeatedly between SHU and observation until he was admitted to ICP on 12/24/01.

I have described many other cases in this report of prisoners who do well in ICP, but then are discharged because of poor behavior. N.P. , discussed in Section IV., is a good example. Poor behavior, rule-breaking and assaultiveness can be part of the clinical picture of SMI. In fact, these behaviors can constitute symptoms of the SMI, or be driven by the mental illness. It is not appropriate to discharge a large number of patients from the treatment program their condition requires merely because they behave badly. Their inappropriate behaviors must be managed as part of their treatment plan, where mental health and security staff collaborate closely in devising an overall management plan. The management of inappropriate behavior inside a treatment setting is standard psychiatric practice; to do otherwise – to discharge them from the treatment program – places them at great risk for further deterioration, and indeed I found this kind of deterioration in many cases I reviewed.

In a correctional setting, it is the responsibility of the mental health staff to identify the prisoners who require very long term or even permanent intermediate care programming, and to do all they can to avoid discharging them from a program such as ICP. I will present another example of someone whose SMI requires long-term assignment to ICP, but whose repeated breakdowns and behavioral problems lead to his recycling between SHU and CNYPC.

EE.Z. **(Interviewed while housed in ICP at Great Meadow on 8/27/03.)**

History: EEZ has been in prison since 1991. He was in SHU between 1996 and a recent admission to CNYPC. He felt the officers harassed him in SHU. He was seeing things and crying a lot in SHU, and was charged for multiple assaults on officers. He believed that staff moved

him from SHU to ICP because we were coming on this tour, and he was convinced they would move him back as soon as we left.

Mental status examination: E.E.Z. was incapable of giving a coherent history, exhibited loose and tangential associations, and was incapable of reality testing. His affect was flat, he was concrete and he was agitated.

Clinical chart: E.E.Z.'s chart is relatively thick. He was admitted to CNYPC with a diagnosis of psychosis, hallucinations were noted, and he was treated with Haldol. There are multiple admissions to CNYPC, all of which involve decompensation. In 2002, he was diagnosed Major Depressive Disorder with Psychotic Features, other times he was diagnosed Schizophrenia. He has also been prescribed Prozac and Risperdal. On 6/25/03, he discontinued his medications. In August, 2003 he was transferred to ICP. (I met him on August 27, 2003). On 9/29/03, he was still in ICP. He was admitted to CNYPC in February, 2004, in a psychotic state due to non-compliance with medications, and again on 11/24/04, regressed and psychotic, with a diagnosis of Schizophrenia, Undifferentiated Type. By 3/25/05 he had been discharged from CNYPC, was in SHU at Sing Sing, was non-compliant with medications and became acutely psychotic and had to be re-admitted to CNYPC. He was also plagued by hypertension and related medical emergencies, and had to be transferred to a medical hospital in the community for medical treatment.

E.E.Z. suffers from a recurring psychotic condition, probably Schizophrenia. His condition deteriorates in isolated confinement. He was transferred to ICP just prior to my inspection, but he did not last long in ICP. He was admitted to CNYPC in an acute psychotic state, and then returned to SHU. He should have been returned to ICP after recovering from an exacerbation of his SMI.

E. Outpatient

Outpatient treatment is available to prisoners in many settings throughout DOCS. Thus there is no "site" to inspect in order to assess the quality or availability of outpatient mental health services. Rather, one learns of the services available by reading policies and other documents, by interviewing prisoners about the care they receive, and by reviewing clinical charts. Besides the observations and opinions I provide throughout this report, the aspect of outpatient mental health treatment within DOCS that warrants further comment here is the treatment available to prisoners in SHU.

Historically NY DOCS Satellite Mental Health Services have only been available at maximum security facilities. As a result, some prisoners who should be confined at medium security or minimum security facilities are sent to maximum security facilities, not because of any security reason, but solely because they are

suffering from mental illness and need more intensive mental health services than are available at the medium (or minimum) security facility. Two illustrative cases are as follows:

B.W. **(Interviewed while housed in observation at Sing Sing on 5/7/03).**

History: This man has been in prison for a few years and in observation for two weeks. He says he has no prior psychiatric history, and was in SHU for only a few weeks prior to having "strange" psychiatric symptoms and being transferred to observation. He is serving a six month SHU term, and prior to SHU he was at Washington Correctional Facility, a medium security facility. He says he sits in his cell in SHU getting nervous, he feels "funny" and his body feels unusually "light." In observation, the only staff he talks to is the group of mental health staff who take him to a room to talk for five or 10 minutes on weekdays.

Mental status examination: This man seems acutely psychotic. He laughs inappropriately, he seems internally pre-occupied and does not establish normal contact, and his thoughts are tangential and there are loose associations. His presentation is consistent with a psychotic episode.

Clinical chart: Progress notes reflect pre-psychotic symptoms by 4/23/03, and he is transferred to Sing Sing RCTP from Washington to R/O psychosis. There is a diagnosis Brief Psychotic Disorder on 5/2/03, and reported auditory hallucinations on 5/6/03. Notes continue to 5/7/03, as he remains in observation and refuses medication. A 5/20/03 note reflects transfer to Clinton Correctional Facility, where OMH staff suspect he is concealing his psychosis. But he remains in a cell (Keeplock), refusing treatment. In other words, he is left to ride out his psychotic episode in maximum segregation in a Keeplock cell with little or no treatment and only monthly reviews.

D.D.Q. **(Interviewed while housed in observation at Clinton on 7/16/03.)**

History: This man has been in prison for 23 months. He is HIV positive, and has "mental problems." He was at Bare Hill Correctional Facility, a medium security institution, in a general population dorm. He was transferred to observation at Clinton, a maximum security facility, when he had persistent suicidal thoughts. Prior to incarceration, he had been admitted to Bellevue psychiatric ward for 13 months after jumping off a sixth floor roof in a suicide attempt. He has been suicidal on and off ever since, and becomes suicidal when he receives bad news. He has never been

admitted to CNYPC. He was in observation during a previous incarceration.

Mental status examination: There is sadness, psychomotor retardation, insomnia, and obsessions about his wife, who died of AIDS in 2001. There is hopelessness, anhedonia (a lack of pleasure in anything), and low self-esteem.

Clinical chart: His chart contains the diagnosis Major Depressive Disorder, Recurrent and Psychotic (1/22/04). He has a long history of repeated suicide attempts, from 1977, with several admissions to observation at maximum security facilities, including the admission to observation at Clinton on 7/14/03 due to suicidal ideation. Medications include several antidepressants. He seems to manage at times in medium general population, on antidepressants, between episodes. Outpatient progress notes from 1/9/04 and 1/12/04 and a treatment plan review from 2/6/04 show him confined in the SHU at Fishkill, a medium security facility.

The fact that prisoners with mental health service needs must be transferred to a maximum security facility to receive the appropriate level of care means that they are being disadvantaged on account of their psychiatric disability.

Outpatient mental health treatment in SHU is very thin, in spite of a concentration of prisoners suffering from serious mental illness in SHU. According to Dr. Bruce Way's 2002 study, 65% of prisoners in SHU are on the OMH caseload, and 32 % of prisoners in SHU are on Mental Health Level 1; this is in contrast to 11% of the total DOCS population who are on the OMH caseload. According to the Special Housing Units Mental Health Needs Study Conducted by CNYPC (5/17/02), Level 1 patients received 1.6 hours of mental health contact in one month, consisting of 1.2 hours cell-side, and 0.4 hours in a private space. The discussion in that study continues: "Clearly there is little mental health clinical contact time with most being 'cell side' – a noisy, non-confidential environment." As it turns out, these figures are actually underestimates of the true number of prisoners in SHU who are on the OMH caseload, as indicated by a 5/18/04 Memo to Roger Klingman, in which Richard Beer explains that as of 11/30/03, "there were a total of 540 SHU inmates on the OMH caseload,... 480 of these inmates were considered seriously mentally ill. In addition to the 540 inmates in SHU who were on the OMH caseload, there were 281 inmates in SHU-200 cells[61] who also were on the

[61] SHU-200 cells are freestanding isolated confinement units that exist in medium security facilities throughout the state. They are constructed as double-cell isolated confinement.

OMH caseload.... Thus, the total number of inmates in SHU and SHU-200 cells who were on the OMH caseload at that time was 821."[62]

Since there is very little in the way of mental health treatment in SHU except medications, cell-front interviews and occasional interviews in a confidential setting, a prisoner with serious mental illness who is not transferred to observation or CNYPC must remain in his cell almost 24 hours per day with little to do and the constant threat of getting into trouble with officers and having his term in SHU extended. **A philosophy of punishment substitutes for a philosophy of treatment, and prisoners with serious mental illness suffer immensely from the harsh conditions, lack of meaningful activities, punitive practices and inadequacies in the treatment program. In short, confinement in a cell, 23 or more hours each day, even with the prescription of psychotropic medications, does not constitute adequate mental health treatment, and causes deterioration in the psychiatric condition of prisoners suffering from mental illness.** Dr. Jeffrey Metzner, a recognized expert on correctional mental health care, has been quoted saying: "If the conditions of confinement involve being locked in a 70-square-foot cell 23 hours a day for months at a time, it is unlikely that patients with mental illness could receive adequate mental health services."[63] I have presented many relevant cases to illustrate the inadequacies of mental health services in isolated confinement, including N.D., N.P., J.Z., A.M., W.Y., V.M., Q.I., B.Q., T.R., W.S., I.V., D.R., T.T.Z., B.B.I., B.P., V.F., V.W., Z.H., Y.N., E.E.A. will present one additional case that illustrates the deficiencies in outpatient mental health services in SHU:

> F.F.L. **(Interviewed while housed in SHU at Sullivan on 5/5/03.)**
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> **History:** F.F.L.'s psychiatric history pre-dates incarceration. He has been in SHU at various institutions. He explained that at Clinton he could not get any help for his mental health problems, so he stopped eating in protest. He was experiencing severe anxiety with tightness and pain in his chest and abdomen. He suffers anxiety attacks when he is locked in a cell and idle, and believes that his current emotional problems became disabling two months after he was locked up in the SHU at Auburn. He was transferred from the Clinton SHU to CNYPC. He reported that in SHU, the mental health staff see him briefly at cell-front and provide no help at all. For example, he told them he was in trouble and needed mental health help from September, 2001 through January, 2002, but only in January, 2002,

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[62] Exhibit No. 460, 1/11/05

[63] In the American Psychiatric Association publication, Psychiatric News, September 21, 2001, p. 6.

did they really talk to him, and then they decided to transfer him to CNYPC. He described anxiety, a feeling the walls are closing in on him, confused thinking and trouble sleeping whenever he is confined in SHU.

Mental status examination: Examination revealed some confusion, tangential thinking, very poor concentration, self-contradiction, delusions about being hypnotized and otherwise controlled by others, and poor contact with the interviewer. He did not seem to be suicidal, nor was he experiencing hallucinations during our meeting.

Clinical chart: FFL S' thick chart confirms he was at CNYPC from 9/18/02 through 11/21/02, and he was diagnosed Psychotic Disorder NOS on 8/28/02. He had at least two other CNYPC admissions. He has evidently been assaultive toward staff, and has spent long terms in SHU and on Keeplock. He is noted to be delusional and paranoid on 9/18/02, not eating for extended periods, and unable to walk for unknown causes. Later notes relate inability to walk due to muscle loss secondary to refusal to eat. He was discharged from CNYPC on the anti-psychotic medication Zyprexa 20 mg. per day. A certificate for transfer to CNYPC in 2002 describes him as "nearly catatonic." He was returned to Sullivan on 11/21/02, briefly evaluated in the mental health unit observation area, and then was returned to SHU, still psychotic and taking Zyprexa 20 mg./day. The psychiatrist opined that he was still delusional, but "functional" in SHU, taking Zyprexa 20 mg. A 6/27/03 Admission Note from CNYPC states he is in SHU, "He is delusional. He has missed 13 meals. He is taking fluids. He thinks if he eats that the FBI will take fluid samples from his body for 'testing'." On 3/25/04 he was housed in SHU and participating in the STP. My concern is that, given the severity of FFL ' mental illness, the fact that he remains in isolated confinement and receives only two hours of programming per day (if he is in STP), this is not the proper setting for him and the mental health treatment is not adequate.

F. Specialized Treatment Programs (STP)

According to OMH Preliminary Reports about the STPs at Attica (18 cells) and Five Points (25 cells), these programs (which were started by OMH as part of the resolution of Eng litigation) were intended to provide enhanced mental health services for prisoners with serious mental illness who do not adjust well in SHU. The components of the STPs are "a. mental health services including group therapy for each inmate for two hours each week day; and b. a joint management committee to discuss the needs/placement issues of SHU inmates." The goals of the STP are to "A. Reduce inpatient admissions and discipline, and B. Stabilize mental health symptoms and

functioning."[64] The programs are housed inside the Attica and Five Points SHUs. At Attica the STP prisoners are housed among the pods of the SHU, while at Five Points they are housed in a separate SHU block. In both STPs, the prisoners are subject to the same daily routines and security protocols as are the other SHU inhabitants, with the addition of the two hours of programming and the joint management committee. The stated duration of the STP program is 12 weeks, but I met prisoners who have completed one twelve weeks stint in STP and then were begun on a second. I also met prisoners who had been in STP and were returned to regular SHU. For the STPs to be useful programs, the time a prisoner spends in STP must be brief, and the aim of the brief treatment must be preparing that prisoner for exit from isolated confinement. I will present an illustrative case:

V.F. **(Interviewed while housed in ICP at Five Points on 3/13/03.)**

History: V.F. told me he has been in prison for six years and will be released next year. He likes ICP. He said he is Bipolar and hears voices. He was arrested (while in DOCS), charged and convicted for throwing in response to command hallucinations, and was given an additional three year prison term. He has been at CNYPC four times, usually returning to SHU when discharged. He says time in SHU has made his mental illness much worse, mostly because there was nobody to talk to. He also told me "If you suffer from depression like I do, you become really, really depressed in SHU – and you start thinking about suicide." He says he has been mentally ill since childhood, and was on SSI for Depression prior to incarceration. He told me that in SHU he tended to stop taking his medications and then his mental illness worsened, but in ICP he is being helped by mental health staff to take his medications regularly.

Mental status examination: He was concrete, flat, and his reports of symptoms of psychosis and depression were quite credible.

Clinical chart: Multiple volumes of V.F.'s clinical file fill a carton. There were psychiatric hospitalizations prior to incarceration. From December, 1999, through February, 2000, he spent most of the time in observation at Auburn while doing a SHU term – he was belligerent, swearing, smearing feces, flooding cell, throwing things, etc. He was not transferred to a hospital because staff felt his behavior was not driven by SMI; yet he continued to be prescribed strong anti-psychotic, mood-stabilizing and antidepressant medications. He cycled repeatedly between SHU and observation and CNYPC and back to SHU. A 5/02 note reflects he is in STP. A 9/5/02 note reflects a plan to transfer him to ICP, and by

[64] Drafts 10/2/02 for Attica and 10/11/02 for Five Points.

10/15/02 he is admitted to ICP. He is returned to the satellite unit at least once, but recovers and returns to ICP. On 6/2/03 he is scheduled for transfer to discharge planning.

V.F. had been an extremely difficult management problem in SHU, likely because his Bipolar Disorder was exacerbated by isolated confinement, had spent much time in SHU, and had been transferred to CNYPC and observation multiple times and back to SHU. Eventually he succeeded in getting out of SHU after a several month stint in SHU enrolled in the STP and then by transferring to ICP, where he has been able to remain on his medications (anti-psychotic, antidepressant and anti-psychotic) for severe Bipolar Disorder with Psychotic features and remain free of tickets.

I toured the Special Treatment Programs at Attica and Five Points, and I witnessed an ongoing program in the room set up for STP group activities at Five Points. The most striking physical feature of the STP is the "cages," individual enclosures for each prisoner while he is taking part in group activities. One of the group rooms (on A-2 housing for STP, low side) at Five Points contains five cages spread along two of the four walls in the living-room sized special room. Each enclosure is approximately the size of a phone booth, they are separated from each other by their lexan walls. Each prisoner is brought in separately and placed in an enclosure, and then the group leader talks to the group. There are a variety of formats, including some that are considered therapeutic and some that are considered educational. OMH staff at Five Points told me that participation in the STP requires medication compliance on the part of the prisoner. Interim Evaluation Reports[65] for the STP note good progress. For example, Attica STP participants had fewer Tier 3 tickets while in STP than they had accumulated previously, there were far fewer admissions to observation, and there was better compliance with psychiatric medications. However, there was no significant reduction in the frequency of admissions to CNYPC and no significant reduction in the number of suicide attempts.

According to the Special Housing Units Mental Health Needs Study Conducted by CNYPC (Draft 5/17/02), prisoners in STP received 21.4 hours of mental health contact in one month in the 43 program slots. However, these prisoners in STP received an average of only 0.9 hours of individual clinical contact in a private setting per month. For prisoners with SMI, this is insufficient treatment to maintain stability in the SHU environment.

Placing human beings in cages can be very degrading. Prisoners I interviewed in STP told me that they have graver concerns about confidentiality and humiliation in STP then they did in SHU. At least in SHU they can choose not to talk to the OMH clinicians who ask them potentially embarrassing questions at cell-front, within earshot of other prisoners and officers, but in STP groups they are required to expose vulnerable material, and officers are either present during the group sessions or

[65] Draft for Five Points STP 7/21/03; Draft for Attica STP 7/23/03

might come barging in at any time. Then, several prisoners told me independently, the officers use the personal material they have learned in the STP groups to embarrass the prisoner in front of fellow prisoners at a later time. The prisoners in the STP are confined in the SHU, and at Attica their cells are scattered throughout the SHU.

I will present two illustrative cases of prisoners whose STP treatment is compromised by the fact that they are housed in SHU and that officers intrude on their treatment and education in the cages:

> P.J. **(Interviewed while housed in SHU and assigned to the STP at Attica on 9/23/03.)**
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> **History:** P.J. has a history of serious mental illness and psychiatric treatment since childhood. He told me the correctional officers are in the room with the prisoners and therapist during therapy group in STP. He has been prescribed Haldol, but was not taking it because he did not trust the correctional officers. He reported hearing voices and feeling very suicidal. He was refusing to go to the yard because he was afraid "the correctional officers will do something to me." He has made approximately 20 suicide attempts. He complained that the correctional officers are privy to treatment in STP and then use the clinical information against the prisoner. He awakes crying frequently.
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> **Mental status examination:** This man was agitated and angry, with some pressured speech. He gave credible reports of auditory hallucinations, he was delusional, and his affect was depressed. He was concrete and there was some evidence of thought disorder.
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> **Clinical chart:** His very thick clinical chart contains diagnoses of Delusional Disorder, Paranoid, and Organic Personality Disorder. At other times he is diagnosed Psychotic Disorder NOS. When he agrees to be medicated, he is given injections of long-acting Haldol, 150 mg. per three weeks, and oral Depakene 1,250 mg. per day. He has been admitted to CNYPC many times since 1989, always being returned to SHU at discharge. He is admitted in a psychotic state, medicated, often restrained, and then returned to SHU, supposedly non-psychotic, taking intramuscular anti-psychotic medication, and re-compensated. However, he repeatedly breaks down again in SHU.

P.J. suffers from a chronic psychotic disorder, is paranoid, agitated and suicidal, he has continually cycled between SHU and observation/CNYPC since 1989; he decompensates in SHU repeatedly and goes to CNYPC where his medications are re-initiated. P.J. is currently in STP with no current medications. He is currently provided very little psychiatric treatment, in spite of the fact that he has a history of serious mental illness and was actively symptomatic at the time of our interview.

R.X. **. (Interviewed while housed in SHU and assigned to the STP at Attica on 9/23/03.)**

History: R.X. has been in prison since age 17. He has been in SHU since 1996. He told me he has seizures, blacks out, cannot remember the event, but wakes having soiled himself. He takes Dilantin for the seizures (not reflected in chart), and he wears a helmet. He was taking Prozac and Risperdal, but "they stopped my psychiatric medications." He has been admitted to CNYPC twice since being in SHU. He has also tried to hang himself in SHU. He was in observation March 6 – 13 at Attica. He told me it is cold in SHU, and officers leave the windows open. He has been behind glass (Lexan) the whole time he has been in the Attica SHU. He did not know why. The noise that continues all night was keeping him from sleeping. He was in the STP program, but he worried about confidentiality since the correctional officers come barging in to groups all the time and talk outside about what prisoners say in groups. He expressed a need for confidential therapy sessions. He said he would like a break with his SHU term, but none had been offered.

Mental status examination: R.X. was wearing a helmet, he had deep bags under his eyes, he exhibited ideas of reference and tangential thinking, and he gave credible reports of depression, suicidality and auditory hallucinations. I observed psychomotor retardation, depressed affect, self-castigation and hopelessness

Clinical chart: The thick chart contains many diagnoses. He was prescribed Zyprexa in 12/99, with a diagnosis Attention Deficit Disorder (Zyprexa is a medication for psychosis, not ADD). On 1/11/01 he was diagnosed Adjustment Disorder with Mixed Anxiety and Depressed Mood and treated with Zoloft 100 mg. (an antidepressant). A 4/4/01 SHU cell-front OMH note reflects that correctional officers say he has not been eating, note reflects depression. Periodic notes in the chart report his claim of auditory hallucinations, he is prescribed anti-psychotics, but his diagnosis is adjustment disorder. Medications are changed periodically, but he has been prescribed anti-psychotics (Risperdal, Zyprexa, Seroquel – one or other, not together) and antidepressants (Prozac, Zoloft – one or the other). He has been in SHU, cycling to CNYPC or observation since 1996, with a long term ahead.

R.X. was un-diagnosed repeatedly, and then notes in his clinical chart reflected psychosis and severe depression even when the diagnosis does not, and he was prescribed medications for psychosis and severe depression. Current placement in STP while housed in SHU is better than what he has had previously, but I am concerned he will complete STP and remained housed in SHU. A CNYPC discharge note reflects that

his extensive SHU term prevents his referral to a treatment setting. He continues to be unpredictable and suicidal. He is in STP, but the Risperdal and Prozac that he says help his mental illness are not currently prescribed. R.X. is clearly not receiving adequate nor effective mental health treatment for his serious combination of disorders and cognitive deficits. His lack of a diagnosis of serious mental illness, despite his obvious needs, means he has no adequate treatment plan in place. For this patient, STP will provide no more than temporary respite from his SHU cell.

I strongly question whether the cages the men are placed in for group events, and the very tight security measures in STP, are really necessary. Consider the fact that at CNYPC many of these same SHU prisoners are permitted to mix with other prisoners in the day room, group meetings, etc., without restraint. Additionally, at the inception of the STP, before the enclosures or cages had arrived, the plan was to conduct STP group sessions without cages, but in smaller groups.[66]

Further, the potential negative effects of treatment in cages or enclosures must be weighed against the therapeutic and security benefits. This is a complicated calculation. The critical variable is whether participation in time-limited STP programming makes it possible for prisoners who had been in SHU for a long time and were likely to remain there indefinitely (since their mental illness is exacerbated and they repeatedly receive tickets in SHU), are able to be transferred out of SHU and remain out of SHU. No matter how rosy the picture painted by OMH preliminary studies of STP outcomes, this aspect of the outcome is as yet undetermined. I met several prisoners who had participated in the STP and then were returned to SHU, including A.M. (discussed in this Report, above) and G.S. (see Case Studies, Appendix D); and I met V.F. in ICP (see beginning of this section), who had been in SHU for a long time, and then went through the STP and was able to exit SHU and be transferred to ICP. Part of the determination of outcome depends on how significant are the "time-cuts" given to prisoners with serious mental illness. There is a policy permitting OMH and DOCS staff to reduce the time a prisoner with SMI must serve in SHU in order to effect a more optimal placement in a therapeutic program. This policy is implemented through Case Management Committees.[67] In practice, from my interviews and chart reviews, patients with lengthy SHU terms are still not provided with sufficient SHU time-cuts, and are not referred in a timely manner to needed treatment programs.

The 7/23/03 (Draft) "Specialized Treatment Program at Attica Correctional Facility Interim Report" and the 7/21/03 "Specialized Treatment Program at Five Points Correctional Facility Interim Report" provide some outcome data for prisoners entering the two STP programs between late 2001 and early 2003. Disciplinary infractions are

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[66] CNYPC Governing Body Meeting Minutes, Dec. 11, 2000.

[67] Case Management Committees (CMCs) were established by regulation pursuant to the settlement agreement in Anderson. CMCs are discussed in further detail in Section IX.

decreased to some extent, participants in the program were still admitted to Satellite Units and CNYPC, but at a statistically significant lower rate, and so forth. Time cuts (for SHU terms) were given to 40% of STP participants at Five Points, and the median time cut was 262 days. At Attica, time cuts were given to 53% of the STP participants, but the median time cut was only 60 days. In terms of housing assignments, at Attica 9 of the 30 STP participants were in general population or ICP six months later, while another 11 were in SHU (one assumes that 10 more were still in STP within SHU). At Five Points, 10 of 22 STP participants were in general population or ICP while 10 others were in SHU.

Since SHU terms can be cumulative and run into many years, and since between a third and a half of STP participants were in SHU six months after they participated in STP, it looks like quite a significant number of prisoners are going through the STP programs and then remaining in SHU after leaving the STP, and it looks like the time cuts are not having a very significant impact on the SHU terms of many STP participants. While such outcomes as the reported decrease in disciplinary infractions and the improved participation in treatment constitute positive developments, the suicide rate did not decline – remember, STP is inside the SHU, so the prisoners are subject to the same harsh conditions (other than two hours per day of STP programming) as other prisoners in SHU. The fact that so many prisoners who go through the STP program remain in SHU means the STPs are not an effective antidote to the problem of prisoners with serious mental illness being in isolated confinement.

I am not optimistic the STPs will succeed in helping many prisoners be released from SHU absent basic changes in the philosophy that guides the use of isolated confinement in DOCS and the attitudes and practices towards prisoners with serious mental illness that I have outlined in this report. After all, the STPs are located in SHU, the prisoners are subject to the routines and discipline of SHU, albeit with two hours in the cages or enclosures that permit group programming, and the enclosures themselves are degrading and not conducive to the formation of a trusting therapeutic relationship. Listening to the complaints about conditions registered by STP participants, they are the same complaints I hear from non-STP SHU inhabitants. In other words, the most important factor is confinement in SHU. The extra programming that comes with STP participation is relatively less important to these men. And the STP participants I interviewed all seem very pessimistic about ever getting out of SHU. One wonders how much meaningful treatment or education can go on in such a setting. Meanwhile, STP participants are still housed in SHU, and suffer all the negative effects of isolated confinement. The two hours per day of programming is not actually sufficient to counteract the negative effects of the SHU confinement that continues while the prisoners are taking part in STP. I will present a case of someone whose mental condition continues to deteriorate in SHU in spite of his being in the STP:

A-4 **(Interviewed while housed in SHU and assigned to the STP at Attica on 9/23/03.)**

History: A-Y has been housed in SHU, with or without STP for three years. He said he receives no mental health care in DOCS and he rarely goes to recreation in SHU because if you are not up when the CO comes around you miss recreation. He averred taking anti-psychotic medications, which he said help, but he said he'd rather not be taking medications because they cause sedation and he does not trust the doctor.

Mental status examination: This man exhibited an obvious tangential thought process, loose associations, pseudo-logic, perseveration, thought-blocking, searching for words, credible auditory hallucinations with internal preoccupation, a flat stare, concreteness and cognitive impairment. In other words, his mental status pointed to a diagnosis of Schizophrenia, pending confirmation by history and chart review.

Clinical chart: Contrary to his denials, this man was treated for Schizophrenia earlier in his prison term, at Arthurkill and another facility. The voices he hears get worse when he is in observation. A 1/2/02 note reflects that he had not been on his psychiatric medications when he was accused of assaulting an officer, the offense that landed him in SHU. He was in the Attica STP in February, 2002, and seems to have continued to be renewed for 12 week STP courses through at least 10/24/03. He is prescribed Zyprexa and Celexa when he complies with treatment. His motivation for STP is erratic, but notes continuously reflect disorganization and thought disorder.

A-Y suffers from chronic Paranoid Schizophrenia, deteriorates in isolated confinement and it does not seem to matter whether he is in SHU with or without participation in STP.

Dr. Shimkunas and Dr. DeVito, in their depositions, admit that there is a long waiting list for admission to the STPs, so there are many prisoners in SHU who are in need of more intensive mental health services who cannot gain admission to STP (See Shimkunas Tr., p. 183; DeVito Tr., pp. 165-166). If STP programming is not significantly enriched and out of cell time increased, and if prisoners are permitted to remain in SHU or return to SHU after completion of the STP program, then the STPs will not succeed in helping prisoners withstand the tremendous stress of being in SHU.

The 2004-2005 Executive Budget Forensic Mental Health Initiatives (Plaintiff's Exhibit 238, 5/26/04) proposes tripling the STP bed capacity, increasing it from 43 beds to 118 beds. Most of the beds will be added at Five Points, and 50 will be in another facility. If prisoners are permitted to be housed in SHU either immediately after completing a stint in SHU with STP, or even after a period of time has elapsed since they completed the STP program, then the STP program will fail in its aims and merely constitute another form of harsh isolated confinement.

G. Substance Abuse Treatment Programs

At least 71% of prisoners in DOCS have a problem with substance abuse by self-report.[68] "Dual Diagnosis" is the co-occurrence of mental illness and substance abuse. Probably the percentage of prisoners suffering from serious mental illness who also have a problem with substance abuse is significantly higher than the 71% of all prisoners who have a substance abuse problem. Thus, for individuals suffering from serious mental illness, concurrent treatment of the mental illness and the substance abuse is required. This requirement is recognized in legislation and practices that govern the Federal CMHS Block Grant Funds that OMH and other state mental health agencies receive to establish Mentally Ill Chemically Addicted (MICA) programs.

There are at least three types of substance abuse treatment programs available to the DOCS population: ASAT (Alcohol and Substance Abuse Treatment); CASAT (Comprehensive Alcohol and Substance Abuse Treatment); and RSAT (Residential Substance Abuse Treatment). Some of the programs are run by DOCS, and some by contracting not-for-profit agencies such as Phoenix House. According to DOCS figures, approximately 20,000 prisoners complete drug treatment programs annually.

The Prison Visiting Committee of the Correctional Association of New York, in its June, 2002, "Report: State of the Prisons," states:

> Many of the DOCS-run programs we observed were compromised by either staff vacancies, lengthy waiting lists or less than enthusiastic counselors. Inmates in most DOCS-run programs reported a great deal of down time – cancelled classes, movies instead of instruction or professionally facilitated groups – and little material of therapeutic value. Unfortunately, the Governor's 2003 budget calls for the elimination of all remaining prison drug treatment programs run by outside agencies.

The Visiting Committee was very concerned that the Governor's budget proposes closing the not-for-profit drug treatment programs that provide for prisoners spending part of their time in treatment within DOCS and then part of their time in treatment in the community. They were also concerned that the 2003 budget eliminates 48 substance abuse counseling positions, reducing the number of slots from 76 to 28. The report continues:

> Moreover, the state's primary substance abuse program – ASAT – has been eliminated in most maximum security prisons, a cutback that has created serious problems.... At Great Meadow Correctional Facility, for example, there is not a

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[68] See New York State Department of Correctional Services, "Identified substance abusers," 2001; and Hal Smith, Donald A. Sawyer & Bruce B. Way, "Central New York Psychiatric Center: An Approach to the Treatment of Co-Occurring Disorders in the New York State Correctional Mental Health System," Behavioral Sciences and the Law Behav. Sci. Law 20: 523–534, 2002.

single drug treatment counselor for 1,680 prisoners. Some of the maximum security prisons have replaced ASAT with RSAT, or Residential Substance Abuse Treatment, but in at least six maximum security institutions there is no substance abuse treatment.

The Visiting Committee points out that prisoners need substance abuse treatment to gain treatment for Hepatitis C, to earn parole or to participate in the Family Reunion Program. The Visiting Committee is also very concerned about the long waiting list for drug treatment. For example, RSAT at Attica accommodates 85 prisoners in a six-month cycle and there are nearly 600 men on the waiting list.

The Visiting Committee's report is in stark contrast with an article Hal Smith, Don Sawyer and Bruce Way published about substance abuse treatment and the treatment of dually-diagnosed prisoners.[69] They accept national epidemiological figures that show that 71% of prisoners have a substance abuse problem, and 90% of the prisoners who suffer from Schizophrenia, Major Affective Disorder and Antisocial Personality Disorder also have a co-occurring drug or alcohol problem. Thus, according to them, 28% of outpatients on the OMH caseload within DOCS, and 33% of inpatients, have a co-occurring substance abuse problem. They proceed to describe the ASAT, CASAT and RASAT programs available to this population within DOCS, as well as pre-release treatment planning. The authors speak in glowing terms of the programs available to prisoners with a substance abuse problem. This assessment is belied by what I observed and what I learned from my interviews with prisoners suffering from serious mental illness and from my review of their clinical charts. CNYPC's own data from 2004 found that 48% of CNYPC outpatients have co-occurring mental illness and substance abuse. This is far higher than the comparable figures in the 2002 report, in which they admitted problems with under-reporting.[70] In my view even the 48% figure still seems low.

I inspected several RSAT programs, and other activities related to substance abuse treatment were pointed out to me when I visited DOCS facilities. For example, there are substance abuse groups in some of the ICPs I visited. But in general, I discovered that there is a shortage of substance abuse treatment programs in maximum security institutions. Prisoners in SHU, and most who are on Keeplock[71] are precluded from substance abuse treatment. The exception is that in some of the ICPs, prisoners on Keeplock status in ICP, are released from their cells to participate in drug treatment and/or or other ICP programs. Most of the prisoners I interviewed informed me they had not been provided the opportunity to partake of substance abuse treatment while in DOCS. Self-study materials, for prisoners in SHU, are next to useless because, as I have

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[69] Hal Smith, Don Sawyer & Bruce Way, "Central New York Psychiatric Center: An Approach to the Treatment of Co-occurring Disorders in the New York State Correctional Mental Health System," Behavioral Sciences and the Law, 20, 523-534, 2002.

[70] "It is clear that not all patients with substance abuse were identified," Ibid, p. 527.

[71] Keeplock is generally 23 hour per day isolated confinement.

explained, they are not able to concentrate and are too emotionally upset to do the lessons. They need professional intervention to attend to their substance abuse problem, and this is not available in SHU.

Prisoners suffering from serious mental illness tend to accumulate in maximum security facilities (for example, they are transferred there for mental health services not available at lower security level institutions) and in SHU; and then they are denied substance abuse treatment which they very much need.

Dr. Fulwiler points out that even at CNYPC, where most of the psychiatric patients suffer from polysubstance abuse by history, substance abuse treatment is mostly limited to self-help/twelve step activities. There is nothing wrong with including 12-step programs in a comprehensive substance abuse treatment program, but they must not be substituted for professionally run groups and treatments. When the population being treated is well-known to have a high rate of co-occurring substance abuse and SMI, and that co-morbidity is known to exacerbate serious mental illness and make treatment more problematic, patients need to be provided a robust substance abuse treatment program that is run by well-trained professionals, and this program has to be continuous with similarly intense substance abuse treatment after the patient is discharged from CNYPC. Since so many patients leaving CNYPC return to a SHU in a maximum security prison, they would not be able to take part in a continuation of the substance abuse treatment, even if such treatment were to be made available at CNYPC.

H. Special Needs Units (SNUs) and Other Programs

Special Needs Units are designed as separate units with full programming for prisoners with Developmental Disabilities (DD), including Mental Retardation (MR). I toured the SNUs at Sullivan and Wende. These units serve the subpopulation with Developmental Disabilities very much like the ICPs serve the subpopulation with SMI. In fact, a large proportion of prisoners with DD and MR also suffer from co-occurring SMI. The main problem I discovered with the SNUs is that there are not enough beds in them to house all of the prisoners in need. I found many prisoners among those I interviewed in SHU, for example, who suffer from Mental Retardation in addition to SMI. They were not housed in SNUs when they received the ticket(s) that led to a SHU term. Had they been in a SNU, as would be indicated for a prisoner with their intellectual deficit, they possibly would not have gotten into the trouble that led to their isolated confinement. Examples of this problem that I have presented in this Report are the cases of T.R., W.V., O.P., D.R., H.N., and D.D. Other relevant cases are included in Appendix D, Case Studies. In the case of O.P., he was identified at Downstate Reception with a learning disability and Schizophrenia, and SNU placement was recommended, but he was never transferred to SNU and wound up in SHU instead. (See Selsky Deposition, pp. 187-198.)

There are other programs that serve useful mental health treatment functions, but are not as prominent in the documents describing the mental health programs. My

discovery of 99 Company at Wende was quite accidental. I was interviewing several prisoners in general population and asked them where they bunked, only to be told by several different individuals who seemed to suffer from chronic serious mental illness that they are from 99 Company at Wende. They receive outpatient mental health services, but 99 Company provides a relatively safe and supportive living environment for these very disabled individuals. Dr. DeVito thinks of 99 Company as a "stepdown" program from ICP (DeVito Deposition, p. 118). Indeed, it functions in that way, even if not officially described thus in OMH literature. In the community, a program such as 99 Company would be called a "three-quarter way house" – i.e. a slightly less richly staffed and less supervised "halfway house" designed as a "stepdown" for patients progressing from a psychiatric hospital to a halfway house to a three-quarter way house and then on to independent living. It seems that 99 Company is known as a cellblock where prisoners with psychiatric disabilities are housed, and the staff are somewhat more helpful to these chronically disabled prisoners then are some others. Stepdown programs serve as an important component in a comprehensive mental health system, and appear to be largely lacking in DOCS facilities. I will present the story of one of the men housed in 99 Company, a stepdown unit:

> L.N. **(Interviewed while housed in general population at Wende on 9/25/03.)**
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> **History:** L.N. has been in prison since 1991. He has been in SHU six times and has been admitted to CNYPC 20 times. He has been in observation often. He was not on medications at the time of our meeting, but he had previously been prescribed Haldol and Risperdal. He had a long psychiatric history. He was on 99 Company, and felt the correctional officers picked on him. He was going to school and seeing mental health staff every other week.
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> **Mental status examination:** He was fairly incoherent, he mumbled, he was flat and concrete, he denied he had any mental health problems and he slumped in his chair. This man was obviously suffering from chronic and persistent serious mental illness; his presentation is consistent with Schizophrenia.
>
> **Clinical chart:** The thick chart is consistent with this history. He was admitted to Kings County Hospital in 1991 with paranoid delusions. By 2000 he had been admitted to CNYPC nine times and was considered for a long-term care ward. He also had many tickets, during the early years of his prison term for assaults. He was consistently considered paranoid and delusional and was prescribed psychiatric medications throughout his prison term. His diagnosis is usually Paranoid Schizophrenia. He has been prescribed Haldol and Risperdal. The last admission to CNYPC in the

chart I reviewed was February to March, 2003, when he was discharged to Wende with Zyprexa 20 mg. b.i.d. He is relatively stable in 99 Company.

The APPU and Meryl Cooper Units at Clinton Correctional Facility are other unique programs that could serve as important components in the mental health delivery system. APPU is on the upper floor of the Satellite Mental Health Unit and its inhabitants are prisoners in need of some degree of protection, and they might need that protection because they are suffering from mental illness. In any case, there is some separation from general population, but there is also freedom to move around the unit and there are enhanced program opportunities. Meryl Cooper is a therapeutic community in the Annex Building that prisoners progress through if they are motivated. There are only a few prisoners in the program who suffer from serious mental illness, and mainly the program is designed to help prisoners prepare for post-release life in the community. I mention these programs as examples of already existing programs and locations that have some potential to serve the population of prisoners with serious mental illness, but are currently underutilized.

I. General Treatment Issues

1. Confidentiality

Confidentiality is a basic prerequisite to mental health treatment, and a basic right of the patient.[72] The Principles of Medical Ethics with Annotations Especially Applicable to Psychiatry dedicates its largest section to confidentiality, requiring the psychiatrist to "safeguard patient confidences within the constraints of the law."[73] There must be confidentiality if there is to be mental health treatment as we know it. No person wants what he or she tells a mental health clinician to be shared with others. Prisoners have a right to privacy during a clinical interview, and confidentiality to the extent that is practical in a prison setting. The 1990 Code of Ethics of the American Correctional Health Services Association (ACHSA) state that the correctional health professional must "provide sound privacy during health services in all cases and sight privacy whenever possible."[74] There are relatively rare instances when security concerns override the confidentiality requirement, for example when a clinician hears from a patient about a serious threat to the safety of others or the security of the institution. These are exceptional cases; the rule is to take great pains to respect confidentiality.

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[72] Hippocrates proclaimed for all physicians: "All that may come to my knowledge in the exercise of my profession or outside of my profession or in the daily commerce with men, which ought not to be spread abroad, I will keep secret and will never reveal."

[73] American Psychiatric Association, The Principles of Medical Ethics with Annotations Especially for Psychiatry, 1995.

[74] Cited in Psychiatric Services in Jails and Prisons, a publication of the American Psychiatric Association, 2000.

Security staff and administrators often ask about a prisoner's mental status. Where policy permits mental health staff to share such information, that is appropriate. But to the extent possible, confidential information in clinical charts should not be accessible to non-clinical staff, conversations between clinicians and prisoner/patients should be protected from breaches in confidentiality, and security staff must be trained to understand that confidential information is shared for specific purposes only and that they, too, must protect the confidential nature of clinical information.

In this regard, cell-front clinical interviews done in isolated confinement units are very problematic. Confidentiality is too easily breached because the sessions are conducted within earshot of prisoners in neighboring cells and corrections officers may be present. As a result, the patient is unlikely to report information that clinicians need to know in order to provide treatment or protect the prisoner from self-harm; the mental health staff's willingness to conduct cell-front, non-confidential interviews is likely to create distrust of mental health staff. In all of the isolated confinement units I toured within NY DOCS, cell-front interviews and meetings occur quite regularly. Of course, mental health staff must make rounds on the tiers if they are to know who would like to talk to them, and they must go see a prisoner who is in SHU or other form of isolation at his cell-front to find out why he failed to come to an appointment. But these meetings should be very brief, no queries about the specifics of the prisoner's emotional condition should be made, and an arrangement should be quickly made to meet in a private and confidential office or room in order to explore further the prisoner's condition and needs. Unfortunately, documentation that I have reviewed suggests that mental health screening evaluations are typically conducted at cell-front in the SHU and Keeplock units, and even medication management by the psychiatrist and counseling sessions by OMH and DOCS staff are conducted at cell-front. (See cases of N.D. and J.J. in this report, or any of a large number of prisoners who have had the psychiatrist visit with them only at cell-front in observation[75]) This practice violates the prisoners' right to a private and confidential mental health assessment.

The SHU Plan of Improvement that has been introduced by CNYPC into the outpatient operations requires OMH primary therapists to see SHU prisoners on the OMH caseload in a private, confidential setting at least twice per month, and for the psychiatrist to have a monthly private meeting with each patient on the OMH caseload, whether or not medications are prescribed.[76] This requirement permits patients more easily to request a private interview, and when they are seen in a private room at regular intervals, they may develop some confidence that they will be able to speak confidentially to a clinician. In this context, "rounds" made by OMH staff on isolated confinement units can serve to set up private interviews with prisoners who desire them, or to check on

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[75] Including J.Z., W.C., A.M., D.D.G., B.B.J., Z.H., V.W. and B.P.

[76] See 4/15/05 Memo from Don Sawyer to Unit Chiefs, "SHU Plan of Improvement."

prisoners who are not appearing for scheduled private interviews. However, this new policy does not address the same problem as it occurs for patients held in Keeplock confinement, and provides for only one contact per month with their primary therapist (not a psychiatrist) for patients in the S-Block SHUs and the SHUs at Upstate (where patients are double-celled in 23 hour isolated confinement) and Southport.[77] This is a significant gap in provisions for confidentiality, both for prisoners in SHU-200 cells (there were 281 prisoners in SHU-200 cells who were on the OMH caseload as of 11/30/03),[78] and for prisoners in Southport and Upstate SHUs. In addition, there are some indications that the SHU Plan of Improvement requirement that prisoners on the OMH caseload be seen by clinicians in a private setting does not fully address the problem of confidentiality. For example, prisoner P.T. testified that cell-front interviews with clinicians last for only two minutes, while private sessions last for five minutes (P.T. Deposition, pp. 40-41).

As I observed during my tours of isolated confinement units, when mental health staff conduct cell-front interviews the prisoners on the tier can definitely hear what is being said, as can security staff as they pass by. Thus, a prisoner is put in a position where, if he wants to talk to a mental health staff member, he must essentially disclose his emotional experiences and the treatment he receives to fellow prisoners and officers. In order to assess the need for medications or a change in medication dosage, a clinician would have to ask the prisoner "Are you still hearing voices?" or "How depressed (or anxious) are you feeling now?" Or, if a prisoner chooses to report that he is experiencing suicidal ideation and needs to talk to someone, he must do that within earshot of other prisoners and custody staff. This is not acceptable by any correctional standard and it falls far beneath the standard of practice in the community.

Great harm is done when confidentiality is breached. For example, when a male prisoner admits to his peers that he is suffering from emotional difficulties or a mental illness, or when he admits he is suicidal, he is likely to be labeled a weakling or worse – derogatory terms such as "crazy" and "bug" are used in many prisons – and then that prisoner is vulnerable to attacks by other prisoners after he is released from isolated confinement. The more obvious negative effect is that prisoners who are in need of urgent mental health care will decide not to let the mental health staff know of their suffering or their suicidal inclination because they do not want to expose themselves to ridicule by other prisoners and non-mental health staff. Prisoners are likely to opt to suffer in silence rather than risk exposure and humiliation. Talking to prisoners at cell-

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[77] Similarly, the problems I described in observation cells within the Satellite Units are not affected by the SHU Plan of Improvement. Contact with mental health staff for patients in observation cells occur at cell-front in the Satellite Unit. This is especially inappropriate since they are the most acutely disturbed patients in the system at the time they are placed in observation. This lack of confidentiality is especially inappropriate since these patients are experiencing acute psychiatric crises at the time they are placed in observation cells.

[78] 5/18/04 Memo from Richard Beer to Roger Klingman.

front does not provide a context in which sufficient trust can be engendered for the clinician to find out what the prisoner is feeling and whether he is planning self-harm. Most of the mental health assessments I reviewed contain very little information, and I have reported in this report many cases where the prisoner was clearly massively depressed or psychotic while the mental health assessment form was ticked "unremarkable" in regard to all signs and symptoms of mental distress. One wonders how many suicides might have been prevented simply by permitting prisoners in isolated confinement to meet privately with the clinician conducting the 90-day mental health screening assessments.[79] In many tragic cases of suicide, the assessment forms do not reflect the depth of the prisoner's despair, and in very many cases that would be because the assessment was conducted at cell-front in SHU, within earshot of others.

2. The Diagnostic Process and the Process of Un-Diagnosis

Diagnosis is the first step to mental health treatment. Absent adequate diagnosis, competent, effective treatment is not going to occur. This section focuses on a disturbing pattern of under-diagnosis or un-diagnosis that I found in a large number of cases, as a result of OMH's misuse of concepts such as "malingering." I will comment on clinicians' repeated failure to conduct a thorough psychiatric assessment, which should include a full psychiatric history, review of the clinical record, and a mental status examination, in order to arrive at an accurate diagnosis. Further, there is a misuse of psychological assessment (testing) in order to discount the existence and severity of mental illness. These practices fall far below accepted psychiatric practice. As a consequence, prisoners with serious mental illness are denied necessary treatment.

a. Making a Diagnosis

Prerequisites to adequate diagnosis include an opportunity to fully evaluate a prisoner's mental health record, a meeting between the individual and a qualified and competent clinician in a confidential setting that engenders sufficient trust for the individual to share his or her experience and difficulties, additional psychological testing or medical tests as indicated, and follow-up assessments as needed. In NY DOCS mental health screening typically occurs at Reception, with a face-to-face interview provided to a subgroup (approximately 40%) of prisoners in Reception. Further opportunities for mental health assessment occur when prisoners request mental health services, during 90-day screenings in SHU and other locations, at the behest of security staff who are concerned about the mental status of a particular prisoner, and during crises requiring emergency evaluations, crisis intervention at satellite mental health units/observation, or hospital admission at CNYPC.

I have mentioned, in this Section, problems that I discovered in NY DOCS at each step in this process. For example, some prisoners with serious mental illness are missed

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[79] The ACA requires 90 day mental health screening assessments for prisoners in isolated confinement.

at Reception for a variety of reasons (some related to the prisoner's denial of symptoms, some to the lack of thoroughness of the examination). Ninety-day mental health screening assessments in SHU often miss the prisoner's obvious illness and disability because they are done quickly at cell-front, prisoners' reports of hallucinations and suicidal intent are downplayed and disbelieved by staff who are too focused on "bad behavior" and its punishment at the expense of thorough diagnostic assessment. Much of the contact clinicians have with prisoners in observation is very brief and occurs at cell-front where there is a lack of confidentiality and insufficient time to form a trusting therapeutic relationship, or the prisoner's wish to be transferred out of observation because of the stark deprivations there motivates the patient to deny symptoms so he or she can attain transfer out of observation. I presented a number of cases in Section VI of this report that illustrate these problems. Here I will focus on a disturbing pattern of under-diagnosis or un-diagnosis that I have found in a large number of cases. I will examine what I consider a misapplication of the concept of "malingering" by DOCS and OMH, and I will comment on what I consider a misapplication of psychological assessment in the diagnostic process (i.e. the disqualification of prisoners from the ranks of those suffering from serious mental illness as soon as psychological testing uncovers "Antisocial Personality Disorder" and/or "psychopathy").

Adequate diagnosis obviously requires clinical acumen, objectivity and a lack of bias, as well as a certain amount of sensitivity on the part of the clinician to the emotional suffering and disability of the prisoner. Regarding the very critical issue of staff bias, I have discovered a clear pattern in many of the cases and clinical charts I reviewed in NY DOCS, a pattern that is cause for grave concern. OMH and DOCS, in far too many cases, are too quick to doubt the authenticity of a prisoner's complaints of emotional symptoms. Once OMH decides that the prisoner has "No Axis I Diagnosis," or is suffering mainly from Antisocial Personality Disorder or Borderline Character Disorder on Axis II, or is malingering or manipulating, DOCS and OMH express insufficient concern about the prisoner's subsequent reports of mental anguish and ruminations about self-harm, and they tend to dismiss or downplay that prisoner's complaints of emotional pain and disability. In the course of interviewing many prisoners in isolated confinement, I found quite a few to be suffering from active psychosis, mania, or depression, or seriously contemplating suicide, only to read in their charts that these same prisoners suffer from "No Axis I diagnosis" or that they score high on the psychological test known as the psychopathy checklist[80]; or that they suffer mainly from an Antisocial Personality Disorder. The implication seems to be that since they are "antisocial" or "psychopathic" their reports of psychiatric symptoms are entirely unreliable, and almost by definition they are feigning mental illness in order to gain something, perhaps a transfer out of SHU.

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[80] Nathan Hare's Revised Psychopathy Checklist, or PCL-R – see Hare, R.D., "A Research Scale for the Assessment of Psychopathy in Criminal Populations," Personality and Individual Differences, 1, 111-117, 1980; and Hare, RD, Hart, SD, & Harpur, TJ, "Psychopathy and the DSM-IV Criteria for Antisocial Personality Disorder," Journal of Abnormal Psychology, 100, 391-398 (1991).

b. "Mad" vs. "bad"

The problem is magnified by the tendency within NY DOCS and OMH to think about "bad-ness" and "mad-ness" in terms of *either/or* dichotomies rather than the *both/and* complexities the phenomenon warrants. Are a particular prisoner's unacceptable acts the result of mental illness or merely reflections of his badness, antisocial personality or psychopathy? According to this overly reductionist logic, if the prisoner is "bad," treatment is unwarranted and a waste of time, and he deserves to be punished. If he is "mad," for example truly suicidal or hearing voices commanding him to carry out illegal acts, he needs more intensive treatment, and there is some degree of mitigation for his bad acts. Reality is a lot more complicated. Not only are people suffering from serious mental illness perfectly capable of manipulating and exaggerating symptoms, but often their tendency to do so is actually symptomatic of their mental illness. And in correctional settings, including NY DOCS, there is a significant population of individuals who are suffering from serious mental illness as well as an Axis II disorder such as Antisocial Personality Disorder[81] – the Axis I and Axis II disorders are not mutually exclusive. These prisoners need effective treatment which addresses both disorders. Of course, even prisoners who are recognized as suffering from serious mental illness are not spared the disciplinary procedures in DOCS , and they are sent to isolated confinement. In fact, many of the prisoners I interviewed in acute psychiatric crises in the Satellite Units informed me that they were facing disciplinary hearings upon their return to SHU.

My findings in this regard are entirely consistent with those of Dr. Angela Browne, who was asked by Commissioner Goord and Superintendent Elaine Lord at Bedford Hills Correctional Facility, in the wake of several suicides, to investigate the mental health program at that institution. In her Final Report in 2002, Dr. Browne comments: "During the TA Team's visit to the BHCF OMH Satellite Unit, we were impressed by the extent to which the Axis II diagnoses of 'Borderline Personality Disorder' and 'Anti-Social Personality Disorder' were used by OMH staff to describe virtually all women referred to OMH because of self-harming and suicidal behavior.... Clinical members of the TA Team were particularly concerned that the application of one or both of these Axis II diagnoses often did not seem to be accompanied by a compassionate treatment plan."[82] My own findings in all the institutions I toured entirely matched Dr. Browne's conclusions, in men's as well as women's institutions.

c. Un-Diagnosis

I employ the term "un-diagnosis" to describe the process whereby the diagnosis for a prisoner who had been diagnosed and treated for a serious mental

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[81] However, I found in many of the cases I reviewed that ASPD is diagnosed without sufficient basis.
[82] See "Addressing Self-Harm Among Mentally Ill and Traumatized Women in Prison: Avenues of Systemic Collaboration Between Mental Health and Correctional Personnel" by Dr. Angela Browne et al., 2002, p. 10 (Pl. Ex. 111).

illness is changed to reflect "no serious mental illness." Usually this change is reflected in a new diagnosis of "no diagnosis on Axis I." Either a less "serious" mental illness such as "Adjustment Disorder" or "Polysubstance Abuse by history" is entered under Axis I; or the "No diagnosis on Axis I" tag is accompanied by the diagnosis of a personality or character disorder on Axis II.[83] Clinical phenomenology is actually quite a bit more complicated than this simplistic characterization captures, and in many cases an Axis II diagnosis such as Borderline Character Disorder, if the condition results in sufficient disability and suffering, can constitute a serious mental illness – but I will stay with the simplified characterization for a moment in order to make a point about the process of un-diagnosing.

Where un-diagnosis occurs, there are usually inconsistencies in subsequent clinical chart notes. For example, there are many cases where a prisoner had been assigned a diagnosis for many years of a SMI, such as Schizophrenia or Bipolar Disorder or Major Depressive Disorder, with many psychiatric hospital admissions on his record, and possibly he or she received Social Security disability benefits in the community on psychiatric grounds, and continually reports that the prescription of strong antipsychotic medications are helpful; and then his diagnosis is changed to "no diagnosis on Axis I" or downgraded to "Adjustment Disorder" or "Polysubstance Abuse" on Axis I, but the anti-psychotic or antidepressant medications are continued in dosages that would only be appropriate for patients suffering from psychosis or severe depression.

High doses of antipsychotic (or mood-stabilizing) medications are not indicated in the treatment of "no diagnosis" or "Adjustment Disorder" or "Polysubstance Abuse." As if the clinicians recognize this inconsistency, there are notes about the medications being prescribed "for sleep" or "for behavior management only." This makes no sense. High dosages of antipsychotic medications only help control behaviors if the behaviors are driven by mental illness. Of course, if high enough doses of an anti-psychotic medication are given to an individual who does not suffer from a relevant mental illness, that individual's behavior will be affected in the sense that he or she will be drugged into sleep or at least into a sluggish, zombie-like state – but using medications with potentially dangerous side effects in this way is entirely unsound clinically and constitutes a serious violation of professional ethics.

I discovered a widespread pattern in NY DOCS, namely, an individual who has a long history of serious mental illness is incorrectly "un-diagnosed" (i.e. his diagnosis is significantly downgraded so as not to reflect the true severity of his mental illness); he is continued on medications that are appropriate (but not sufficient treatment) for his actual serious mental illness and not appropriate for the downgraded diagnosis; and then he is returned to SHU, where he decompensates anew because of the harsh conditions and inadequate treatment in isolated confinement. All the while, there is no treatment plan,

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[83] Axis II is the slot in a DSM-IV diagnostic formulation where such diagnoses as Antisocial Personality Disorder (ASPD), or Borderline Character Disorder are recorded.

and the un-diagnosis and the prescription of medications are not justified in the chart. It is my strong impression that after a prisoner has been un-diagnosed, he or she is much less likely to be subsequently admitted to the inpatient facility at CNYPC, regardless of his or her clinical needs.

In the following case, the diagnosis is changed from Bipolar Disorder to no diagnosis on Axis I except a history of polysubstance abuse:

V.J. **. (Interviewed in observation at Clinton on 7/16/03.)**

History: V.J. had been in observation for nine or ten days when I met him. When asked why he was in observation he said "they stopped my medications at Auburn for no reason." He had been in long-term Keeplock until he received a ticket for fighting and was sent to SHU. Previously he had been in ICP at Auburn because he was "very depressed and suicidal." Dr. Melendez refused to prescribe medications when he first arrived at Clinton, but when I met him he was prescribed Seroquel 200 mg. twice per day (a newer, "atypical" anti-psychotic medication), and he was scheduled to begin taking antidepressants on the day of our meeting. In March/April, 2001, he was admitted to CNYPC where his diagnosis was Bipolar Disorder and he was prescribed Zyprexa, Haldol (both anti-psychotic medications) and Benadryl. He told me he cries a lot, he is very sad, he cuts himself, he cannot sleep, and he had lost a lot of weight, but on the anti-psychotic medication, Zyprexa, he gained back the weight. Even though he knows the medication helps him, in SHU he often stops taking it and then his condition deteriorates. He says it is difficult to stay on his medications in SHU and he only sees mental health staff for a few minutes at cell-front.

Mental status examination: This man was sad, displayed psychomotor retardation (slowing of thought, speech and activity – a sign of depression), was self-castigating and expressed a lack of hope. He credibly described auditory hallucinations telling him to harm himself, which he called his conscience. My mental status exam is consistent with a diagnosis of severe depression and psychosis.

Clinical chart: The chart corroborates his history. Pre-incarceration psychiatric hospitalization is noted. A 3/2/01 Progress Note at Five-Points reflects recent transfer from Collins C.F. because of suicide threat. He is agitated or anxious, a history of auditory hallucinations is noted as well as a pre-incarceration history of hyperactivity disorder in childhood. Diagnosis is Bipolar Mood Disorder NOS. Medications prescribed include the anti-psychotic agent Zyprexa, 5 mg. b.i.d. (This is within the range of dosages of this medication prescribed in the treatment of Schizophrenia and other

psychotic disorders.) On 3/14/01 he was admitted to CNYPC with the diagnosis Bipolar Disorder with Psychotic Features, and medicated with Zyprexa 20 mg. per day (a strong dose, even for someone suffering from psychosis). On 4/4/01 he was discharged from CNYPC to Wende, and on 4/10/01 his diagnosis was Bipolar Disorder I with Psychotic Features, and he was prescribed Zyprexa 10 mg. twice per day. A SHU mental health Assessment on 8/6/03 reflects crying so hard that the clinician is unable to assess orientation. He was moved to observation. An 8/19/03 admission to CNYPC followed his assault on a CO and 2 weeks in observation. Then, in stark contrast to all of this history, a 9/5/03 Psychological Evaluation by Dr. Michael Guariglia at CNYPC finds this prisoner to suffer from "no Axis I diagnosis except polysubstance abuse," finds he scores very high on Hare's Psychopathy Checklist, diagnoses Antisocial Personality Disorder, opines that psychiatric hospitalization would not benefit him, and suggests possible malingering. After being thus un-diagnosed, he is discharged from CNYPC, but his discharge medications include Seroquel 300 mg. twice per day, "for sleep," and Celexa 20 mg. per day "for depressed feelings," and it is noted that his admission diagnoses, Bipolar Disorder and Intermittent Explosive Disorder, had been "ruled out." In September - November 2003, he was in SHU at Clinton, often refusing his Celexa but accepting Seroquel. A 2/27/04 Progress Note reflects he is in SHU and continues to be suicidal. And by 2/29 he was in observation in the RCTP. By 10/22/04 he had been re-admitted to CNYPC, and would be returning to SHU.

Thus, this man with a long documented history of Bipolar Disorder with Psychosis, a long documented history of psychiatric hospitalizations, and treatment over many years with anti-psychotic and antidepressant medications with good therapeutic effect, was "un-diagnosed" by psychological testing while at CNYPC in September, 2003 (after our interview), but then was discharged with Seroquel 300 mg. twice per day "for sleep." Seroquel is an atypical or new generation, very strong antipsychotic medication with many negative side effects, and 600 mg. per day is a very strong dosage even for an individual suffering from Schizophrenia or Bipolar Disorder with Psychosis. It would certainly not be appropriate to prescribe this medication at this dosage for someone who is not psychotic. The fact that it is noted in the chart the medication is being prescribed "for sleep," implies to me that the prescribing psychiatrist understood that the prescription of this medication at this dosage would signify to any psychiatrist reading the chart that the patient suffers from psychosis, and thus the denial implicit in the words "for sleep" is either a disingenuous ruse to support the inappropriate un-diagnosis, or it reflects unacceptably poor clinical practice. Similarly, Celexa 20 mg. per day is a full therapeutic dose of that antidepressant medication – if this prisoner is not depressed, why is it prescribed? In fact, when he was transferred to observation in the Satellite Unit on 2/29/04, he should have been almost immediately transferred on to CNYPC. It seems clear that his un-diagnosis played a major part in clinicians' decision to keep him in

observation and return him to SHU instead of transferring him to CNYPC where he could have undergone the treatment his condition required.

Here is another illustrative case, where the diagnosis is downgraded from Bipolar Disorder to Antisocial Personality Disorder:

> E.R. **(Interviewed while housed in SHU at Auburn on 10/29/03).**
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> **History:** I E.R. had been in SHU for the recent six months. He was prescribed Seroquel 300 mg. b.i.d. (a strong dosage of an anti-psychotic medication), Neurontin 400 mg. b.i.d. (a moderate dosage of a mood-stabilizing medication), and Paxil (an antidepressant medication). He has been on psychiatric medications for three years, and they help some, but being in SHU makes his mental symptoms much worse. He told me he gets depressed, then he gets mad, then happy, then he cries – and all the while he doesn't know why. He was in a psychiatric hospital for three years prior to incarceration – he was paranoid and hearing voices. He had a lot of trouble in GP because of being paranoid. He reported that if he doesn't take his medications he finds himself cussing out the correctional officers and then he gets in trouble. Command hallucinations and paranoia were prominent in all the trouble he gets into.
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> **Mental status examination:** This man was very intense, his right eye drifted outward, he gave credible reports of auditory/command hallucinations, was clearly experiencing ideas of reference (paranoia), had a thought disorder that led to very poor reality testing, and exhibited hypomanic agitation and pressured speech. He was incapable of abstracting and displayed poor judgment.
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> **Clinical chart:** This prisoner's chart contains OMH notes as far back as 1992, when his diagnosis was Manic Depressive Disorder (another name for Bipolar Disorder), and a history of multiple pre-incarceration psychiatric hospitalizations with ECT (electric 'shock' treatment, usually administered only in very serious cases of psychosis or depression) and the prescription of anti-psychotic medications (Haldol, Thorazine). By 1995, he was diagnosed Adjustment Disorder with disturbance of conduct (i.e., he had been "un-diagnosed" in spite of the long history of serious mental illness and intensive psychiatric treatment). By 1997/1998, his Mental Health Level was 1 or 2 and he was diagnosed Bipolar or Mood Disorder, and his diagnosis on an outpatient treatment plan of 4/15/99 was "Depressed with some psychotic symptoms." A 7/16/01 Treatment Review Plan from Upstate noted "Client has struggled to adjust to his SHU environment. Reported increase in auditory hallucinations, increase of depression and mood swings." He took Seroquel, Paxil and Neurontin at

least through 8/3/02. But on 4/14/03 he is at the Auburn OMH Satellite and his diagnosis is changed by the psychiatrist and therapist to Antisocial Personality Disorder. On 6/11/03 he is refused for STP because his illness is not serious enough, i.e. he does not have a Mental Health Level 1 nor a diagnosis of SPMI. In 4/04, he is transferred to another facility to serve a 12 month SHU sentence for self-harm and destruction of state property. (It seems very likely that this man's un-diagnosed serious mental illness, i.e. Bipolar Disorder, drove the behaviors that resulted in disciplinary tickets.) The psychiatrist continues the Paxil and Seroquel and Neurontin, but claims there is no Axis I diagnosis.

This man is clearly suffering from chronic psychosis with a severe mood disorder. Like V.J. and many others I interviewed, he is prescribed atypical anti-psychotic medications (Seroquel), antidepressant (Paxil) and mood-stabilizing medications (Neurontin), even though he has been un-diagnosed (after many years of documented serious mental illness he is deemed to suffer from "No Axis I diagnosis"). Even if E.R. had been properly diagnosed, the prescribed medications would likely not be effective in overcoming the negative effects of isolated confinement on someone with serious mental illness.

I am left to wonder how OMH staff have succeeded in "curing" a serious mental illness that typically follows a waxing and waning course over a lifetime, and I am left to wonder what these strong and potentially toxic medications are being prescribed for. In SHU, his condition worsens, so the un-diagnosis puts him in harms way.

Sometimes an individual who is suffering from serious mental illness will say something inaccurate, such as "I am only fooling, I don't really hear voices," when in fact he is hearing voices and, as an additional sign of his psychosis, he changes his mind frequently and says inappropriate things. If the clinician grabs hold of the one statement that he is "only fooling," and looks no further for signs that he is truly suffering from psychosis, then he is at risk of being un-diagnosed and having needed treatment discontinued. It is unprofessional and below the standard of practice for a clinician to take the prisoner's statement at face value and to look no further at the psychiatric history and other signs of serious mental illness. Indeed, Dr. Shimkunas found in a study of suicides in NY DOCS in 2000 that virtually every prisoner who committed suicide had denied suicidality shortly before death.[84] Often statements such as "I was only fooling about hearing voices" constitute blatant denial on the part of a patient who is frightened that he might be insane, and this kind of denial is often seen among prisoners who fear that the stigma of mental illness will lead to victimization and other negative

[84] Dr. A. Shimkunas "Division Paper on Prison Suicide," Aug. 29, 2000. He notes that: "...patients may hide their true suicidal intention to convince staff to permit them the freedom they seek to carry out their final act."

consequences in prison. I will describe such a case, where the diagnosis was downgraded from Psychotic Disorder to Adjustment Disorder:

DD.B **(Interviewed while housed in SHU in a single cell at Upstate on 7/19/03.)**

History: DD.B had been in SHU for four consecutive years. He had no history of psychiatric treatment until he was treated at Rikers Island at age 21, hearing voices and paranoid, and he was prescribed Risperdal. He complained he has been trying to get psychiatric care at Upstate and is not able to get help. He was admitted to CNYPC in 1999, when he believed that there was a conspiracy between police and correctional officers to "get" him. His medications were discontinued at CNYPC. In 2001 he came from Clinton PC to Upstate SHU. He had lit his cell on fire three or four times at Clinton, and had been to observation many times. He has also been to observation at Upstate many times. He has tried to hang himself and burn his cell, usually because he is intent on killing himself, but also he is very angry. His emotional problems are much worsened "in the box." He was in observation for 16 or 17 days in November and December, 2002 following a serious suicide attempt. At that time he pleaded for medications to help him with his depression, but was not prescribed anything.

Mental status examination: He reported that he regularly talks to himself, feels paranoid - as if others are out to harm him - and he avers several First Rank Symptoms (signs of psychosis), including thought insertion and broadcast. He reported hearing voices, but his main problem was depression. He was clearly very depressed, with psychomotor retardation. He felt worthless and hopeless, and thought often of suicide.

Clinical chart: The chart confirms the history he presented. Upon admission to Upstate on 4/24/03 he carried a diagnosis of "Adjustment Disorder with Disturbance of Conduct," and he was admitted to OMH outpatient services with a MH Level 3, but on 5/22/03 his level was changed to 6 and he was discharged from the OMH caseload. There is an admission to CNYPC on 6/10/99, when he was found to be having auditory hallucinations, confused, regressed in behavior, and delusional, with a diagnosis of Psychotic Disorder NOS. He was prescribed Prolixin and Risperdal. He cooperated in treatment at CNYPC, but then, evidently because he wanted to stop taking his medications, he told staff he had fabricated his symptoms. He was given a two week trial off of medications and was deemed to be doing well, and was sent back to Clinton. His discharge diagnosis was Adjustment Disorder. There were six observation admissions between 1998 and 2002, auditory hallucinations were

documented on 11/29/02 and 12/5/02, depression off and on documented in 11/02 and 12/02, and he was returned from observation to Upstate SHU without medications on 12/13/02. A psychiatric evaluation in the Progress Notes for 7/24/01 documented history of hallucinations, delusions and psychotic episodes in the past while incarcerated, with no signs of psychosis at that time and no medications indicated.

D.D.B. is intermittently very depressed and psychotic and has a history of psychotic episodes dating to age 21 when he was at Rikers Island. He suffers from serious mental illness but is viewed by OMH as malingering because, after convincing several clinicians that he was in fact psychotic and being sent to CNYPC, he claimed to be faking his psychiatric symptoms in order to get off medications. OMH staff have relied upon this episode to rule out serious mental illness, a step that is clinically inappropriate. OMH has disregarded his psychiatric instability, and instead he is repeatedly admitted to observation with no treatment plan capable of alleviating the repeated exacerbations of his mental illness. He continues to cycle repeatedly to observation and has been prescribed very potent and potentially toxic psychiatric medications. It is likely that he is manipulative, and either exaggerates or denies symptoms for secondary gain, but this does not mean he is free of serious mental illness. A two week trial off of medications is not long enough to determine that he no longer needs medications. Usually when someone suffering from chronic psychosis stops taking medications, we can predict another decompensation in a matter of months, not weeks. In addition, D.D.B. was being returned to SHU, where the conditions would be likely to induce another psychotic episode after the medications were discontinued. D.D.B. is clearly someone who both suffers from serious mental illness and exaggerates or falsely denies symptoms, especially when he feels threatened and needs protection and when he wants to stop taking medications.

Often very disturbed individuals attempt to "feign sanity" for various reasons. They may want to avoid hospitalization, they may want to discontinue medications that cause bad side effects, or, particularly in prison, they may want to avoid the stigma of mental illness. **But OMH staff seem to grab hold of any momentary indication from these prisoners that they are falsifying their symptoms, and then, they tend to write off all future complaints from these individuals as inauthentic manipulations.** Thus, as soon as OMH staff begin to believe that a prisoner is "merely malingering," and too often OMH staff jump to this conclusion when a prisoner scores high on Hare's Psychopathy Checklist, the prisoner's subsequent complaints about psychiatric problems and suicidal inclinations are not taken seriously. In some of these cases, the staff literally write in the progress notes something like "the inmate informed me he was faking the voices"; the subsequent notes reflect a drastic downgrading of the diagnosis on account of that admission (to "no diagnosis on Axis I," or "primary diagnosis: Antisocial Personality Disorder on Axis II"), and then the prisoner continues to exhibit psychotic, manic or depressive symptoms, and continues to be prescribed strong psychiatric medications. However, his or her signs and symptoms are not believed by staff and the real signs and

symptoms are labeled as manipulations, malingering or both. When I examine the prisoner, he or she is clearly psychotic or depressed and suicidal on mental status examination. Because OMH staff do not sufficiently acknowledge their patients' illnesses, and the symptoms and behaviors associated with the illnesses, they do not intervene appropriately in the disciplinary process on their patients' behalf.

NY DOCS prisons each have a designated OMH service level. Patients who are un-diagnosed and have their service level altered may then qualify for a transfer to a facility that would not accept the prisoner were his serious mental illness correctly diagnosed. For example, policy precludes confinement of prisoners at mental health needs level 1 and 2 at Upstate and level 1 at Southport. But when I inspected those two facilities, I met quite a few prisoners whose obvious serious mental illness and psychiatric disability should have placed them at Mental Health Level 1, and should have precluded their transfer to these institutions.[85]

Prisoners with SMI who are designated Mental Health Level 1 or 2 are precluded from confinement at Upstate, where prisoners are generally double-celled. Prisoners are also generally double-celled at Five Points and in medium security facilities with SHU S-Block Units. Prisoners with serious mental illness should be exempted from double-celling. For SMI prisoners, double-celling creates an intolerable stress and is likely to exacerbate their mental illness. In the minority of cases where the "fit" between cellmates is optimal, the company a cellmate provides can serve to alleviate some of the stress of isolated confinement. For the large majority of prisoners with serious mental illness, however, the "fit" between cellmates is far from optimal, and is often toxic or even deadly. As a consequence of bad fits or because some prisoners with mental illness cannot get along with any cellmate under segregation conditions, tensions mount, fights erupt, sexual assaults and rapes occur, and the company of another prisoner in one's cell becomes as severe a stress, or an even more severe stress, than the isolation and idleness. Thus, prisoners with serious mental illness who are un-diagnosed are at risk of being double-celled and getting into trouble. I will present an illustrative case.

Q.H. **(Interviewed while housed in SHU at Upstate on 7/17/03.)**

History: Q.H. had been at Upstate SHU for one year, with one more year of SHU to go. He was on the OMH caseload, he said, with a diagnosis of Schizophrenia. He told me that when he gets angry, he gets confused and hears voices, and much more so in the Box. He shared that he did not think it was right for him to have a cellmate, given his mental illness, but he had one. He told me he had to work very hard at not getting angry so he would not get into more trouble, but it was much, much more difficult for

[85] Including at Upstate: Q.H., K.Z., W.Y., F.Y., O.R., at Southport: F.O., H.N., and N.D. - see Case Studies for complete notes.

him to control his anger in SHU, and with another guy in his cell. He has seen lots of prisoners lose their tempers in their cells in SHU, and this frightens him. He told me he ignores his cellmate when either of them gets angry.

Mental status examination: This man exhibited concreteness, flatness, a thought disorder, and credible history consistent with chronic Schizophrenia, including hallucinations and delusions.

Clinical chart: The chart shows he is or has been prescribed Thorazine, Sinequan and Remeron, with a diagnosis of "Hallucinogen Persisting Perceptual Disorder." It is noted he is hearing voices in the period 12/01 through 2/02. He is noted to be "paranoid" in 1989. His diagnosis on screening forms on 9/2/99 and 1/8/02 is Paranoid Schizophrenia. There are also less serious diagnoses. He is also noted to suffer from tardive dyskinesia (a serious neurological side effect of older antipsychotic medications, involving involuntary movements).

This man suffers from chronic psychosis and is prescribed psychiatric medications, but his diagnosis is down-scaled and he is confined in a double-cell. The prison does not have mental health services for prisoners requiring Level 1 or 2 services.

d. Subsequent Events Disprove the Un-Diagnosis

In a number of cases, the clinical course following the change in diagnosis makes very apparent the incorrect diagnosing of these prisoners. I found several cases where a prisoner was un-diagnosed, returned to SHU, and subsequently given less intensive treatment (or given psychiatric medications inappropriate for the downgraded diagnosis and then inadequately monitored). Because there is no treatment plan sufficient to manage the prisoner's mental illness, the prisoner ultimately decompensates and requires to observation or CNYPC. The following two cases illustrate this point. In the first, the diagnosis was downgraded from Schizophrenia to no serious mental illness on Axis I, and in the second the diagnosis was downgraded from Schizophrenia to no serious mental illness on Axis I.

T.P. **(Interviewed while housed in observation at Auburn on 10/29/03.)**

History and mental status examination: I passed this man's observation cell at Auburn, and he was eating his own feces at the time. He had been in observation since 10/27 (three days). He shuffled into the interview room saying "I'm eating my shit, and that's all." He was in a Ferguson gown (a one-piece frock designed to be indestructible by hand). He refused to be interviewed (but he had to have agreed to come to see me in an office), he closed his eyes and leaned forward. At his request, I ended our encounter.

Clinical chart: This man's chart reflects a long psychiatric history, admission to OMH in 1997, a diagnosis of Schizophrenia, Undifferentiated Type and ASPD, and he has been taking medications off and on since 1993, including Haldol and Zyprexa (an older anti-psychotic medication and a new, atypical anti-psychotic medication). He had been admitted to CNYPC approximately ten times. He is noted to eat his feces and set fire to his cell, and he is repeatedly admitted to observation and then returned to SHU. By 12/30/03, he was back in observation/RCTP for smearing feces, and the treating psychiatrist opined that his behavior was purposeful and not psychotic, he was started on Remeron (an antidepressant medication), "as a management response, rather than the treatment of a mental illness." On 1/2/04 he was returned to SHU, and by 1/8/04 his medications were discontinued because "he does not want them." He continued to have medications started and stopped, and be re-admitted to RCTP, until he was seen by another psychiatrist, Dr. Lieu, on 3/8/04, and she must have found enough signs of Axis I pathology (e.g. thought blocking, a sign that indicates active psychosis) to recommend sending him to CNYPC with a diagnosis of Schizophrenia by history. A 6/5/04 note at RCTP reflects his return from CNYPC and the fact that he no longer wishes to take medications.

This man clearly suffers from Schizophrenia and requires antipsychotic medications, other modalities of psychiatric treatment that are not available in SHU, and a non-stressful setting if he is to remain in remission. But the treating psychiatrist thinks he has no Axis I diagnosis and is merely manipulating to get to CNYPC. After several months of cycling between SHU and observation and going on and off medications, he is sent to CNYPC by another psychiatrist with a diagnosis of Schizophrenia (CNYPC notes not available), thus exposing the inappropriateness of the treating psychiatrist's earlier clinical opinions.

A.L. **(Interviewed while housed in SHU at Auburn on 10/29/03).)**

History: A.L. began his SHU term with 45 days of Keeplock at Sing Sing, and he was sent to Upstate to do the 45 days. He acquired more tickets in SHU. He came to Auburn in February, 2003, and explained to me, "they stopped my medications without giving me a reason." He has not been seen by mental health staff at Auburn except at cell-side on rounds, and has not seen a psychiatrist. He has told staff he is suicidal and needs the anti-psychotic medication, Seroquel. Last September he attempted suicide by overdose in response to command hallucinations. They stopped his medications when he was in the hospital, and after that there he reported that there was an increase in his hearing voices.

Mental status examination: This man was clearly quite depressed, delusional, gave credible reports of command hallucinations, exhibited psychomotor retardation and some bizarreness, and was quite concrete.

Clinical chart: The chart corroborates much of the history this prisoner presented. He is prescribed (anti-psychotic) Seroquel, 300 mg. twice per day, plus (antidepressant) Paxil. He had a diagnosis of Schizophrenia, Undifferentiated, and ASPD in Screening at Downstate on 5/31/91, and a diagnosis of Paranoid Schizophrenia on several other occasions early in his term. Evidently, it was decided during a CNYPC admission in May, 1993, after he was sent there for "bizarre... agitated paranoid behavior," that he had no serious mental illness. But on 9/25/96, he was at the Green Haven Psychiatric Satellite Unit/observation and the anti-psychotic medication Haldol, plus Cogentin, were prescribed. He was given a diagnosis of Schizophrenia, Undifferentiated – thereby reversing the un-diagnosing that had occurred at CNYPC three years earlier (again, Schizophrenia pursues a waxing and waning course, this does not mean that an individual afflicted with this serious mental illness has "no diagnosis on Axis I" during remissions, rather he should be diagnosed "Schizophrenia, in remission" and be continued in treatment). He was transferred to Auburn on 2/19/03 while being prescribed Paxil 20 and Seroquel 600 per day. The psychiatrist saw him on 3/3/03, doubted he was psychotic, and discontinued Seroquel – there is no mention of concern about overdose. By 3/12 he was in observation for suicide ideation and a report that voices were telling him to harm himself. The psychiatrist continued to see him monthly, at cell-side or in a private interview room, with a therapist who saw him every two weeks. His diagnosis was changed from depression with psychosis to an Axis II problem. A 9/3/03 STP screening form contains the diagnoses Depressive Disorder and ASPD. By 9/22 he was in the Infirmary for a hunger strike which he began when placed on loaf for a disciplinary offense. He was adjudged by OMH not to have a psychiatric problem, but by 9/26 he had overdosed on several different medications and stated the voices told him to do it. The psychiatrist, who doubted there ever were hallucinations, discontinued the medications because of the overdose (this is not clinically indicated if he needs an antidepressant – rather, the medication should be continued but with close monitoring – an overdose is preventable if a prisoner in isolation is monitored and not permitted to accumulate a large supply of pills).

Because serious mental illness tends to follow a waxing and waning course over a lifetime, with periods between acute breakdowns of relative quiescence, a lack of obvious symptoms does not mean the patient no longer suffers from SMI and no longer needs treatment. In fact, continuous treatment provided during remissions is crucial for maintaining stability and preventing recurrences of acute episodes. Based on the large

number of cases I reviewed that reflected a pattern of un-diagnosing followed by provision of less intensive and inadequate mental health services, it is my belief that un-diagnosing is a serious problem within OMH, and that the foregoing cases are not rare or exceptional.

e. Malingering

Malingering, the fabrication or exaggeration of psychiatric symptoms for secondary gain, certainly occurs in prison.[86] There is a strong desire to escape culpability for certain behaviors or to gain placement in a more tolerable setting. The clinician must be aware of the possibility of malingering so that scarce mental health resources will not be squandered on prisoners who are not in fact suffering from a psychiatric disorder. On the other hand, **over-utilization of attributions such as "malingering," "merely manipulating," or "no diagnosis on Axis I" by frustrated clinicians can blind the clinician to the presence of serious mental illness. The unfortunate result of such over-reliance is often un-diagnosis or erroneous under-diagnosis which in turn can lead to inadequate treatment.** Repeatedly in the cases that I reviewed, OMH staff referred to a prisoner as manipulative or "faking" or "willfully" breaking rules, when in fact that prisoner suffers from serious mental illness.

What clinicians often fail to realize about the problem of malingering is that those prisoners who feign or exaggerate symptoms often do simultaneously suffer from serious mental illness. Particularly within the prison environment, because prisoners have limited control over their resources and limited access to clinical staff, there is a strong incentive to exaggerate or manipulate in order to get help. For instance, a prisoner who is genuinely ill but is unable to access treatment, may exaggerate symptoms so he will be "noticed" by staff who can secure treatment for him. I have already provided several illustrative cases, but I will add another particularly illustrative of this problem, where the diagnosis was downgraded from Schizophrenia to "no diagnosis" on Axis I and Antisocial Personality Disorder on Axis II.

> I.A. **(Interviewed while housed in SHU at Five Points on 3/13/03, and enrolled in STP.)**
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> **History:** I.A. had been in SHU for about eight years and received approximately 100 disciplinary tickets. He was taking Depacote (a mood stabilizer utilized by psychiatrists mainly for the treatment of Bipolar Disorder), Haldol and Zyprexa (both anti-psychotic agents). He has been at CNYPC and in ICP. He told me he believes he has "psychic powers." He told me of talking out loud to himself, and the other prisoners and staff making fun of him.

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[86] Kupers, Terry, "Malingering in Correctional Settings," Correctional Mental Health Report, 5,6, March/April, 2004.

Mental status examination: I. I.A. exhibited obvious loose associations, internal preoccupation related to hallucinations, thought insertion and projection, agitation, and severe ideas of reference including the conviction his food was being poisoned. His gestures and facial expressions were bizarre. In other words, his presentation is consistent with active psychosis.

Clinical chart: The clinical chart corroborates his history. A 9/26/01 Core History from Auburn OMH Satellite Unit includes a Diagnosis Psychotic Disorder NOS, R/O Schizoaffective Disorder. He was admitted to CNYPC on 2/2/01 and again on 3/26/01 due to danger to self. It was noted he had a history of psychosis, delusions and paranoia, and had made two prior serious suicide attempts, one a hanging in prison on 9/8/00, the other an attempt to shoot himself in 1994. He was not eating for six days, believing his food was poisoned. He was also put on "loaf" as a disciplinary penalty. He was delusional, and had poor hygiene. Dr. John Wilson did a psychological assessment and diagnosed Paranoid Delusional Disorder (1/23/01), R/O Paranoid Schizophrenia; and ASPD, R/O Paranoid Personality Disorder. He was readmitted to CNYPC for the third time on 5/18/01, and discharged on 8/9/01. His diagnosis early in the third admission to CNYPC was Psychosis NOS, and he was treated with anti-psychotic medications (Risperdal and Haldol). But this time his discharge diagnosis was Axis I, "No Diagnosis," and Axis II "Antisocial Personality Disorder." His diagnosis was switched from Psychosis NOS to ASPD and back again several times through 2001. He had to be re-admitted to CNYPC from 11/30/01 through 1/23/02, his fourth CNYPC admission, and psychological testing reflected poor prefrontal lobe functioning, neologisms, autistic thinking, oddities of association, psychotic thinking, and so forth – he also registered high in psychopathy. When he was admitted to CNYPC on 2/7/02, his fifth admission, paranoid, mute, acting bizarrely, decompensated and repeatedly assaultive, he was medicated over objection with Risperdal - disproving the theory that he did not suffer from a serious and persistent mental illness. He was eventually admitted to STP. Until then he had been left essentially untreated despite his psychotic condition, apart from involuntary medications during his repeated acute psychotic crises.

A well-documented history of SMI prior to incarceration should alert the staff that such illness is likely present, even if the individual is currently in remission. When such a prisoner has been seen in observation for multiple suicide attempts or referred to a correctional psychiatric facility, it becomes even more likely that this inmate in fact suffers from a serious mental illness and may pose a significant risk of self-harm. In each of these situations, the prisoner is likely suffering from SMI even if he may be simultaneously manipulating or exaggerating his symptoms. If the clinician

diagnoses malingering and continues to prescribe strong anti-psychotic or mood-stabilizing medications, or continues to place the prisoner on suicide watch in observation, then something is very wrong with this picture. The following case further illustrates the detrimental effects un-diagnosis (downgrading the diagnosis from Schizophrenia to no mental illness in this case) can have on the prisoner.

I.D. **(Interviewed while housed in SHU at Auburn on 10/30/03.)**

History: I.D. came to prison in 1988. He was being prosecuted in court for "throwing" an unhygienic substance. A psychiatrist examining him for the court in that case declared him incompetent to stand trial. He had a strong psychiatric history prior to incarceration, including admission to Kings County Hospital G Bldg. (the psychiatric ward) on multiple occasions. He took psychiatric medications for quite some time in prison. He brought a file of documents with him to our interview, and showed me the report of a court-related psychiatric evaluation with a diagnosis of Paranoid Schizophrenia, and a conclusion that he is not competent to stand trial. He also showed me a letter from Executive Director Hal Smith of CNYPC, 7/2/03, declaring that he had been at CNYPC for a competency program and is no longer incapacitated as of 3/21/03. Meanwhile, he had been sitting in SHU without the benefit of significant mental health treatment since returning from court and the finding of incompetence. There is a note in one of the documents about a "competency restoration program" at Auburn, per Dr. Langbart, but he says he has only seen Dr. Langbart a few times, for a few minutes each time, the last time being four months ago. He was taking no psychiatric medications.

Mental status examination: This man was disheveled, he looked around in paranoid fashion, his affect was inappropriate, he was incoherent and exhibited bizarre gestures. He was disoriented as to person, being unclear who he was and also confusing me with the Judge. He reported auditory hallucinations with internal preoccupation. He had severe ideas of reference. He had strong First Rank Symptoms, including thought insertion and broadcast. I asked him a series of typical questions that are used to determine competency, and it seemed clear he was not competent – for example, he did not know the difference between a Judge and a clerk.

Clinical chart: I.D. 's chart fills an entire carton. Over many years he has spent an inordinate amount of time in SHU, and was considered belligerent, with diagnoses varying from Paranoid Schizophrenia to Adjustment Disorder to Schizophreniform Personality Disorder. By 2000 he was admitted to CNYPC for the eighth time for swallowing razors and other objects. He had been treated in DOCS with various anti-psychotic

> medications, including Navane. He had been diagnosed Paranoid Schizophrenia, but also Exhibitionism. He was also diagnosed Paranoid Delusional Disorder. On 11/28/01, his diagnosis was Depressive Disorder NOS and he was prescribed Zyprexa 20 mg. per day and Seroquel 400 mg. twice per day, as well as Zoloft 100 mg./day. A 7/23/03 note from Mr. Hilton reflects the clinician feels this prisoner is manipulative, and "He has maintained for some time in SHU without MHU intervention." (This note seems to confirm his report that he has been ignored by OMH staff). But he continues all the while to cycle from SHU to observation and back to SHU, swallowing razors periodically and otherwise convincing staff he was a serious suicide risk. A 7/24/03 note by the psychiatrist concludes no mental illness and that this prisoner should stand trial for his law-breaking. Yet the psychiatrist notes bizarre behavior such as wearing a mat as a hat. He was subsequently re-admitted to CNYPC and released to Elmira May 9, 2005 (per NY DOCS website).

It is very possible, from history and mental status, that the acts that led to criminal charges being brought were driven by mental illness, whether or not I.D. meets the criteria for an insanity defense. He receives frequent tickets in SHU. This man is suffering from psychosis and depression, either Paranoid Schizophrenia or Schizoaffective Disorder, with acute symptoms, including ongoing hallucinations, delusions and bizarreness. He was declared incompetent in the course of an outside court case. He is supposedly currently in a "competency restoration program," but actually he has been un-diagnosed, is not being treated, is being denied medications, is being left in SHU where his condition clearly is poor, and he rarely sees the psychiatrist. Dr. Langbart, the treating psychiatrist who did a competency evaluation of I.D. for the court, testifies that he does not know about I.D. 's long psychiatric hospitalization for Schizophrenia during childhood, does not know about his past suicide attempts and does not know which anti-psychotic medications have proven effective for him (has he not reviewed the clinical chart nor taken a thorough history?), but his opinion that I.D. suffers no Axis I diagnosis and is diagnosed with Antisocial Personality Disorder on Axis II would not be affected if he did know about that history (Langbart Deposition, pp. 86-99).

Research in the social sciences has demonstrated that, in a "total institution" (prison, state psychiatric hospital, large group home), when mental health services are inadequate, scarce or difficult to access (for example, where mental health staff in SHU or observation find they must resort to seeing prisoners at their cell-fronts instead of taking the time to examine them in a private, confidential setting), people may need to resort to extreme measures or behaviors to be "noticed" and get the care they need. In other words, they suffer from psychosis (and/or mania or depression with suicidality) and they manipulate – it is not a case of either/or. This unfortunate pattern is especially prevalent in isolated confinement units, where the conditions of confinement are such that prisoners complain often, and as a result staff can become relatively inured to their

complaints. The problem with the staffs' excessive concern about being manipulated is that the harsh conditions of confinement and the lack of a real opportunity for the prisoner to develop a trusting confidential therapeutic relationship can lead to repeated suicide attempts and breakdowns in depressed and psychotic prisoners.

f. Methods for Detecting Malingering

There are reliable methods for distinguishing between malingering and bona fide mental illness. These methods are well-known, accepted psychiatric practice. For trained clinicians who perform thorough evaluations, it is relatively easy to differentiate between a "mere malingerer" and a prisoner with serious mental illness. For example, the clinician might ask about the quality of reported hallucinations, and watch for disingenuous responses, defensiveness, or responses that do not seem to fit a known clinical syndrome. The clinician needs to have a layered, complex method. The clinician must assess the match between a person's story and their facial expressions, affect, body language, and so forth. The clinician compares the objective mental status examination (what the psychiatrist observes, for example the "internal preoccupation" that often accompanies hallucinations or the pressured speech and flight of ideas that suggest mania) with the subjective history and reportage (what the examinee tells the clinician), and checks to see if there are inconsistencies. For example, people who suffer from Schizophrenia not only hear voices, they also suffer from a pervasive thought disorder. It is quite easy for someone to falsely claim they hear voices, and many people who are trying to fake mental illness will make such a claim because they believe that hallucinated voices prove their madness. However, it would be much more difficult even for an accomplished actor to mimic for very long the loose and tangential associations and the bizarreness that are critical parts of the clinical picture of Schizophrenia. These signs of "thought disorder" are objectively observed by the clinician doing the examination. No matter how thoroughly a prisoner has studied the signs and symptoms of mental illness, there are noticeable inconsistencies in the way someone intent on faking a mental illness or telling a false story presents the symptoms.

I ask prisoners who may be suffering from psychosis whether they experience Schneider's "First Rank Symptoms." These are symptoms that reflect a psychotic failure to distinguish inner from outer reality, or to establish a healthy boundary between self and other. For example, does the prisoner think someone is putting thoughts into his head, or does he think his thoughts are being broadcast to others? Does he believe someone else is controlling his movements, or that his thoughts are controlling the behaviors of others. The presence of First Rank Symptoms is strong, but not absolute, evidence of psychosis, and should be routinely investigated in the process of diagnosing.

There are many other ways to assess the reliability of an interviewee. The following are standard assessment methods. Wherever possible, information provided by the interviewee can be corroborated by documents and information from others. The internal consistency of the interviewee's story can be evaluated. The story an interviewee

tells in the present can be checked against the story he has told others in the past. The interviewee's intelligence must be taken into consideration – i.e. a very intelligent person is more capable of reading about a disease or syndrome and mimicking its signs and symptoms, whereas a less intelligent person is likely to make obvious mistakes in the process. The secondary gain (benefit of having more severe symptoms) can be assessed. I become skeptical when I interview a prisoner who has been diagnosed a "malingerer" and yet denies he is mentally disturbed, is quite resistant to mental health treatment, and does not want to be moved to a treatment unit for prisoners with psychiatric disabilities. Where is the secondary gain?

I typically check prisoners' complaints about their environment by touring and observing the environment. The prisoners I interviewed in NY DOCS do not know all the others I interviewed. The fact that so many of them gave approximately matching answers to questions I asked about practices in the units suggests strong reliability. In general, my mental status examination of prisoners in DOCS tended to be consistent with the symptoms they reported (e.g. prisoners who reported auditory hallucinations also seemed to me to have flat affect, to be incapable of abstracting and to exhibit a certain degree of thought disorder – and this is a consistent picture of a particular mental illness, Paranoid Schizophrenia). In other words, in cases where I opine that the prisoner suffers from serious mental illness, I found great consistency between prisoners' reports of symptoms and past history (subjective), my mental status examinations (objective), and my review of clinical charts and all peripheral data.

g. Psychological Assessment

I have discovered quite a few cases among those I reviewed where the psychologists at the psychiatric hospital, CNYPC, performed psychological assessment (often Hare's Revised Psychopathy Checklist PCL-R), on a prisoner who had a diagnosis of serious mental illness, concluding that the prisoner was feigning mental illness or attempting self-harm for secondary gain. The testing psychologist then recommended that the prisoner be put on a Behavior Management Plan because further psychiatric treatment was unlikely to be effective. Frequently, the prisoner scores high on the psychopathy checklist and the psychologist will conclude that the prisoner is not credible. **What the psychologist does not seem to recognize, however, is that nothing about one's score on the psychopathy checklist establishes or rules out the diagnosis of serious mental illness.** And the diagnosis of Antisocial Personality Disorder (ASPD) on Axis II does not preclude the presence of a serious mental illness on Axis I. Any well-trained psychologist would continue to assess for serious mental illness. Numerous prisoners I interviewed were un-diagnosed by psychologists at CNYPC, but were, when I examined them and reviewed their clinical records, clearly suffering from serious mental illness.

Psychological Assessment can be a very useful component in the diagnostic process. Richard Rogers provides a thorough review of the literature as well as a

practical guide to the assessment of malingering.[87] Dr. Rogers is a highly regarded expert in the field, and he provides guidelines for the psychological assessment of malingering.

I find that psychological assessment instruments such as the MMPI-2, while potentially very helpful in theory, can be quite misleading in practice. I have reviewed tests administered by correctional psychologists who conclude that there is "no Axis I diagnosis" and the prisoner is "merely malingering," and yet when I review the raw test data I find statements that this profile is consistent with malingering or with confusion secondary to a psychotic thought process. In other words, the clinician could easily be putting forward a biased conclusion that is not entirely backed up by the raw data. Psychological assessment for the purpose of uncovering malingering can be quite problematic. Inordinately high scores on the F or "Fake/Bad" scale of the MMPI-2, for example, might reflect malingering or exaggeration of symptoms, but could just as likely reflect gross mental disorganization on the part of a very disturbed individual, or even a failure to comprehend the test questions on the part of someone with a brain injury, limited education, or impaired intellectual function. In fact, there is a well-known class bias on the validity scales of psychological test instruments. To rule out these possible fallacies, the test administrator must be skilled in differential diagnosis. The point, however, is if the psychologist who is interpreting the raw test data thinks in terms of "either/or" dichotomies such as "mad" vs. "bad", and has grown excessively wary of prisoners who try to manipulate staff, then he or she brings a bias to the interpreting of ambiguous test results, and too often concludes the prisoner is "merely malingering."

I have already presented the cases of V.S. and I.A., cases in which I strongly believe the psychologists at CNYPC erred in their psychological assessment,[88] and the subsequent prescription of strong psychiatric medications (to prisoners with "no diagnosis on Axis I") or the prisoner's subsequent clinical course (repeated admissions to observation for suicide attempts or psychotic breakdowns) disproves the un-diagnosing.

Richard Miraglia, Director of the OMH Bureau of Forensic Services, has testified that Psychopathy is a form of mental illness (Deposition, pp. 237-238), that a high psychopathy score on the Hare Checklist does not indicate whether an inmate has an Axis I diagnosis (p. 238), that inmates with active psychosis should not be administered tests for psychopathy because the results will be inaccurate (p. 243), that testing for psychopathy is not useful in terms of planning suicide intervention and crisis intervention

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[87] Richard Rogers, Clinical Assessment of Malingering and Deception (New York: Guilford, 1997).

[88] As a psychiatrist, I do not administer psychological assessment instruments. Psychologists perform "psychological testing." But this does not mean I have no expertise about psychological assessment instruments or psychological tests. During my entire career I have worked closely with psychologists, and I have often requested "testing" or psychological assessment to help me with the diagnostic process. And it is the psychiatrist's job to examine critically the psychological assessment. After all, even when testing is requested, the psychologist and psychiatrist collaborate in arriving at a diagnosis.

(p. 239), and that it is not appropriate to utilize a test for psychopathy in determining whether malingering is present (pp. 243-244). **Unfortunately the substance of Mr. Miraglia's testimony is not followed in practice by OMH clinicians. Nor has Mr. Miraglia, or any other CNYPC administrator, promulgated a policy to guide the appropriate use of such testing. The inadequacies I have discovered in the psychological assessments I reviewed seem to be a result of this gap in administrative oversight.**

After the psychologist at CNYPC writes a long report concluding that there is "No Axis I diagnosis" or that the prisoner is malingering, from then on OMH clinicians resist diagnosing the mental illness that is clearly presented by that prisoner in subsequent acute breakdowns or crises. This inattention to prisoners' obvious distress further compounds the harm caused by eliminating Axis I diagnoses. Rather than belaboring this point, I will present one more illustrative case, where the diagnosis was downgraded from Bipolar Disorder with Psychosis to no serious mental illness on Axis I.

E.E.M. **(Interviewed twice, once while housed in SHU at Five Points on 3/13/03, and then briefly while housed in SHU at Attica on 9/23/03.)**

History: E.E.M. has spent 13 of his 16 years of incarceration in SHU. He told me voices commanded him to do awful things such as to swallow a razor, that the voices get worse when he is in SHU, but then officers give him tickets for swallowing the razor and he receives punishment of more time in SHU. He said he used to weigh 280 pounds but now weighs only 230, and this was because he is kosher but the staff do not respect his dietary/religious needs. He complained of being stripped naked while in observation in winter, when it was freezing cold. He was at CNYPC three years ago. He complained he was threatened by correctional officers for talking to me, and that correctional officers throw feces at him and put feces in his food.

Mental status examination: This man told me he hears voices and exhibited bizarre facial expressions and clear signs of internal preoccupations that are consistent with current hallucinations. His mannerisms were bizarre, with inappropriate grimaces and sounds. He complained, in obvious delusional fashion, that the correctional officers rape him repeatedly. His thoughts were often tangential, his associations loose. His affect was often inappropriate and disconnected from the content of our conversation. He was concrete and incapable of abstraction. In all these ways, his mental status examination, on two different occasions, pointed to psychosis, most likely Schizophrenia.

Clinical chart: The chart for this prisoner is very thick. He was admitted to CNYPC for the first time in 1986. During another admission, on 7/2/97 his diagnosis was "Bipolar Disorder, Most Recent Episode Mixed, Severe, W/Psychotic Features" and Anti-Social Personality Disorder. An OMH Mental Status Report for Division of Parole of 1/31/97, by Dr. Faruki, M.D., states: "His hospitalizations are caused by his becoming very psychotic, paranoid, hallucinated and violent. At times he was suicidal. He responded well to psychiatric treatment in CNYPC." Medications prescribed include Depakene, 500 mg. bid, Navane, 10 mg. bid and Klonopin, 1 mg. bid. An update on 12/17/97 during a CNYPC admission notes "He showed a positive response to antipsychotic medications." There were many admissions to CNYPC and observation; repeatedly, progress notes reflect bizarre and regressed behaviors and that anti-psychotic medications improved his condition, which deteriorated anew once he was returned to SHU. There is a 10/20/99 admission to CNYPC, Mental Health Level 1, because he smeared feces, set fire to his cell and cut himself. He was taking Prozac 40 mg plus Zyprexa 20 mg., but was assigned a Diagnosis of Borderline Personality Disorder with Adjustment Disorder. A 5/20/02 Psychological Consultation by Dr. John Wilson includes neuropsychological testing that uncovered no abnormality, and reported an IQ test from 1995 that indicated functioning at the bottom of "Low Average" range. Dr. Wilson continually referred to E.E.B.'s suicide attempts and hallucinations as manipulative and/or fabricated, but then he wrote that in February, 2000, E.E.B. repeatedly banged on his cell door for 36 hours or more, and that he was injected on an emergency basis with the antipsychotic Thorazine. Dr. Wilson repeatedly reported delusional material that this prisoner shared during their two hour interview, but dismissed all of it as if it were merely manipulative. Referring to a neurological examination that was conducted on 4/7/92 for the prisoner's headaches, where no abnormality was found, Dr. Wilson concluded that the negative findings "implicitly indicate that (the prisoner's) self-reports are not reliable." Dr. Wilson administered two psychological assessment instruments (tests), the MMPI-2 and the Hare Psychopathy Checklist, and concluded from these tests and his interview and review of records that this prisoner suffered only from polysubstance dependence and severe personality disorder, and no major mental illness on Axis I. In a Behavior Management Plan, Dr. Wilson recommends strongly against any future psychiatric hospitalization for E.E.B. Subsequent to Dr. Wilson's report and the decision not to re-admit this prisoner to CNYPC in the future, he was still prescribed strong anti-psychotic medications and returned to SHU.

It is impressive that many clinicians' narrative reports on E.E.B.'s progress notes clearly reflect psychotic symptoms, but these reported symptoms are not consistent

with the lesser diagnoses applied to the patient after Dr. Wilson did his assessment (they are consistent with many earlier diagnoses). The medications subsequently prescribed are more appropriate for the psychotic symptoms reported than for the lesser diagnoses. Dr. Wilson continually errs in his clinical logic. For example, consider his opinion that the lack of positive findings on a neurological examination for headaches is proof that this patient's self-reports are unreliable. From neurological examinations I have performed and according to neurologists I have consulted, most reports of headaches lead to negative findings on neurological examination; this does not mean the patient was feigning the pain, rather that there was no tumor or other tissue pathology detectible. Dr. Wilson's conclusion in this regard is entirely contrary to established clinical principles, but it evidences a consistent bias that leads Dr. Wilson to disregard this patient's symptoms and distress. As I pointed out earlier, a high score on the Hare Revised Psychopathy Checklist in no way rules out the presence of serious mental illness.

It is also incorrect for Dr. Wilson to dismiss evidence of E.E.B's psychotic symptoms as mere "self-reports." In fact, there are many assessments by psychiatrists and psychologists in the chart, with diagnoses of serious mental illness, admissions to the inpatient psychiatric hospital, and positive effects of prescribed anti-psychotic and other medications. These are not simply "self-reports" of psychiatric problems; rather, one has to assume that the clinicians recording narrative progress notes, making the diagnoses, and prescribing hospitalization and strong medications made objective assessments of this prisoner's mental state prior to writing their diagnoses and their orders. In these and other instances, Dr. Wilson proves he is so certain that E.E.B's bizarre presentation confirms malingering with no serious mental illness, that he ignores a much more likely interpretation of the entire clinical picture: E.E.B suffers from serious mental illness that is made worse when he is placed in SHU, and that his illness, as is predictable with Schizophrenia and other forms of SMI, has followed a waxing and waning course. E.E.B's mental illness is so severe that he requires long-term psychiatric hospitalization; his illness certainly should preclude him from isolated confinement. Furthermore, Behavior Management Plans (by OMH policy) should be utilized only when conventional treatment interventions have failed, but in E.E.B's case, he has not had the benefit of appropriate treatment, which for him would be long-term psychiatric hospitalization.

E.E.B is a very difficult patient, and he has refused treatment (often it was a matter of the mental health clinician visiting him at cell-front and the prisoner refusing to talk). His behavior has been obnoxious. Moreover, he has been very manipulative and makes up stories. People with serious mental illness are known to do such things, and they can pose very serious management problems, as this prisoner has obviously done. The result of an overly strenuous and single-minded attempt on Dr. Wilson's part to read all of the history and all psychological tests as evidence of "mere malingering" misses the complexity of this case and the likely co-existence of both very serious and persistent mental illness and obnoxious, manipulative behavior. (I will discuss Behavior Management Plans in the next section.)

G. G. Hay found that five of six patients in whom he thought he identified feigned psychosis eventually developed Schizophrenia.[89] Others have pointed out that the collection of signs and symptoms that are interpreted as malingering today might actually preview an impending psychotic decompensation or suicide in the future. The consequences of missed diagnoses of serious mental illness and erroneous un-diagnosing are that prisoners who are prone to break down under the stress of isolated confinement, and who are prone to acting out and receiving tickets when their psychiatric condition deteriorates in SHU, are left to endure an essentially indeterminate term in SHU.

The process of un-diagnosis is evidenced in DOCS and OMH studies. For example, CNYPC has conducted two "Special Housing Units Mental Health Needs Studies" (Draft 5/17/02 and July 16, 2004, hereinafter referred to as the SHU Studies), focusing on the approximately 500 SHU cells located at 11 OMH Level I facilities (I inspected ten of the 11). The 2004 study states: "The overall percentage of major mental illness among SHU inmates has dropped 47% (from Jan., 2002 to March, 2004)... This reduction is statistically significant.... The reduction in psychotic disorder and major mood disorder diagnoses are each statistically significant." A DOCS Memorandum from Program Research Specialist Leslie Kellam to John Culken, Director of Mental Health Services, and others, dated June 24, 2003, on the subject of "SHU Placement and OMH Levels," states: "Between 1999 and 2003, the percentage of OMH Level I inmates in regular SHU or Keeplock cells declined over 40 percent, from almost 16 percent to nine percent. At the same time, the percentage of these inmates in treatment settings increased from one-third to 40 percent."

A decrease of 40% in the number of prisoners suffering from SMI in SHU would be quite impressive, if it reflected a true decrease. The July 16, 2004 SHU study goes on to state: "The decrease of Level 1 inmate-patients in SHU with psychotic disorders and major mood disorder indicates that inmate-patients in SHU with psychotic disorders and major mood disorder indicates that inmate-patients with serious mental illness are either being diverted from, or transferred out of SHU." But the study fails to consider the possibility that a significant number of the same prisoners remain in SHU or cycle back to SHU, but in the intervening two years between the two studies they have been un-diagnosed. If this were the case, then it would not be true that "inmate-patients with serious mental illness are either being diverted from, or transferred out of SHU." In fact, it would mean a significant number are being inappropriately un-diagnosed, and that is why the 2004 study concludes there are 40% fewer prisoners with SMI in SHU. In order to investigate this possibility, I, along with Dr. Carl Fulwiler, requested Plaintiff's counsel to prepare a list of prisoners whose names were included in both the 2002 SHU Study and the 2004 SHU Study, and to list the diagnoses they were assigned in 2002 and 2004. That list is very interesting, and is attached to this report as Appendix F. Twenty two of the prisoners who were in SHU in 2002 and again in 2004, at the times the two

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[89] G.G. Hay, "Feigned Psychosis – A Review of the Simulation of Mental Illness." British Journal of Psychiatry, 8-10, 143 (1983).

studies were done, had their diagnoses changed from an Axis I diagnosis that constituted serious mental illness to an Axis II diagnosis that did not, or had their diagnosis changed from an Axis I diagnosis to "no diagnosis." (Other prisoners had their diagnoses changed from an Axis II disorder to no disorder, or had their mental health needs level changed to one indicating less need for treatment. For example, H.N. was diagnosed Major Depressive Disorder, Recurrent, in 2002, and Antisocial Personality Disorder in 2004; Y.Y. was diagnosed Schizophrenia, Paranoid Type in 2002, and Antisocial Personality Disorder in 2004; D.D.A. was diagnosed Schizoaffective Disorder in 2002, and Antisocial Personality Disorder in 2004; I.D. was diagnosed Major Depressive Disorder, Recurrent, in 2002, and "no diagnosis" in 2004; and so forth.) Major Depressive Disorder, Recurrent; Schizophrenia, Recurrent Major Depressive Disorder, Schizoaffective Disorder are all examples of serious mental illnesses that tend to pursue a waxing and waning course over a lifetime. Thus it is peculiar that someone who was suffering from Schizophrenia in 2002 would be suffering only from Antisocial Personality Disorder in 2004. As it turns out, I interviewed seven of the 22 prisoners who were thus un-diagnosed: H.N., Y.Y., C.Cz., E.EM., A.H., I.D. and Q.S., C.Cz., E.EM. and I.D. are presented in this report; the other cases are summarized in the appended Case Studies). My own assessment of the seven individuals of this group of prisoners in SHU was that all were clearly suffering from serious mental illness; this assessment was based on their history as well as my mental status examinations.

I draw two conclusions from this brief review of the SHU Studies: Prisoners with serious mental illness in SHU are being inappropriately un-diagnosed and denied needed mental health services, and the SHU Studies are faulty in that they do not consider this likelihood and thus the conclusion that there has been a 40% reduction in the number of prisoners in SHU who suffer from SMI is entirely erroneous and misleading.

3. Behavior Management Plans and the Proposed Behavioral Health Units

a. Behavior Management Plans

Policy and Procedure for Behavior Management Plans (the "BMP Policy")[90] states that a Behavior Management Plan in the outpatient setting is indicated when: "1) Active patients have been determined to engage in self-injurious behaviors for secondary gain; 2) It has been determined that their self-injurious behaviors are unrelated to signs or symptoms of major mental illness; 3) Traditional forms of mental health intervention, such as pharmacotherapy, verbal therapies, and inpatient treatment, have proved ineffective in reducing the propensity to self-harm; and/or 4) It has been determined that there is a substantial risk of reinforcing strategic self-injurious behaviors by providing inpatient treatment."

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[90] CNYPC Patient Care Services, 8/25/03, OMHCNY 0079529.

I will comment about these four indications for Behavior Management Plans. Regarding numbers 1 and 2, as I have explained, OMH clinicians are often wrong about self-injurious behaviors being primarily motivated by secondary gain. OMH clinicians have, in so many cases, incorrectly un-diagnosed the patient, and therefore they simply are not in a position to perceive the connection that truly exists between the self-injurious behavior and a serious mental illness. Regarding number 3, OMH has not really provided a trial of traditional forms of mental health intervention; rather the patient has likely been in isolated confinement where the conditions have exacerbated the mental illness, has likely been prescribed medications that do not work when the patient is in isolated confinement and is not undergoing other forms of mental health intervention such as intensive psychotherapy and psychiatric rehabilitation. Additionally, contacts between OMH and the patient have been mostly at cell-front and therefore the confidentiality that is a prerequisite for "traditional forms of mental health intervention" has not existed. Further, the patient's stints in observation have been more punitive than therapeutic. Regarding number 4) in the indications for Behavior Management Plans, **there is no evidence that any risk exists of "reinforcing strategic self-injurious behavior," because no research has been conducted on prisoners who have had adequate mental health treatment and have not been subjected to the destructive effects of isolated confinement.**

Other aspects of the BMP policy are particularly troubling, and, as I will discuss shortly, suggest that the BMPs, as currently conceived and configured, are not only clinically inappropriate and harmful to prisoners, but constitute a violation of clinical and ethical standards. For example, pursuant to the BMP policy, OMH may advocate with DOCS for additional deprivations beyond those that might otherwise be applied to a prisoner in isolated confinement. These might entail fewer amenities (showers and reading materials) and less out-of-cell time. This contrasts with OMH's contention that they have been unable to intervene with DOCS when DOCS disciplines a prisoner, except in very limited ways; here, it is OMH itself that is imposing the harsh conditions and deprivations.

OMH has produced a study of the effectiveness of Behavior Management Plans.[91] The report begins by asserting: "Empirical evidence revealed that traditional mental health interventions served to increase the incidents of self-injury rather than decrease the number of such incidents for this subset of inmate/patients." There is no credible evidence to support this assertion. In fact, of the cases listed where Behavior Management Plans have been instituted, almost all of the patients have spent long periods in isolated confinement with entirely inadequate mental health treatment, and have been transferred repeatedly to observation where the program is more punitive than therapeutic. But the OMH report goes on to state that patients on Behavior Management Plans were admitted to CNYPC less often than in the past – ignoring the fact that the

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[91] See "Behavior Management Plan Effectiveness Report," July, 2004, by Sharon Barboza-Whitehead, Chief Psychologist, CNYPC.

BMPs require that the patients not be admitted to CNYPC. Thus, it appears likely that when prisoners needed to be hospitalized, they were not. Their admission to observation did not decrease after the plan was initiated. And there does not seem to be a significant decrease in the rate of self-injury after the inception of the plans. The report does show a decrease in the number of incidents reported to the Office of Risk Management after the plans' inception – but this finding is not discussed, and there are so many variables involved in terms of which incidents are reported to the Office of Risk Management, that it is difficult to make any valid conclusions from that trend. For example, as Superintendent Lord points out, acts of self-harm may go unreported (Lord deposition, p. 88).

I encountered a number of prisoners who I believe suffer from serious mental illness, and who have been identified by OMH as candidates for Behavior Management Plans.[92] Generally, the individuals I met who have been placed on Behavior Management Plans fit the description Hans Toch provides of the "Disturbed, Disruptive" Prisoner.[93] In other words, many of them suffer from serious mental illness and their disruptive and/or assaultive behaviors present staff with very difficult management problems. In the last section (Section VI.I.2) I described an unfortunate and error-ridden process whereby certain disruptive prisoners are un-diagnosed, even though they are suffering from SMI. Often an intermediate step in the process of un-diagnosing and assigning a Behavior Management Plan is the attribution of Psychopathy – and in DOCS and OMH, this attribution usually results from psychological assessment or testing at CNYPC. In the following two examples a high score on the Psychopathy Checklist precedes the prisoner's placement on an inhumane behavior management plan.

> T.J. **(Interviewed while housed in Keeplock at Auburn on 10/30/03).**
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> **History:** T.J. first entered prison in 1990. He had a history of mental illness prior to incarceration. In 1996 he was given a five year SHU term. He became very depressed and isolated in SHU, he heard voices, he tried to hang himself at Eastern, he was transferred to Green Haven, he could not handle being in SHU and he experienced despair and tried to hang himself again. He was in and out of observation and has received tickets for self-harm. In April, 1999, after attempting suicide several times and cycling back and forth from SHU to observation, he was admitted to CNYPC for six months. He was taking Zyprexa the whole time. At the beginning of his third prison term, his Zyprexa and Prozac were discontinued. He was unable to get OMH to re-initiate medications, and he

[92] Including T.J., D.D., E.E., M.J., T.R., Y.N., V.J., D.W., D.R., and C.E.

[93] Toch, Hans & Kenneth Adams, Acting Out: Maladaptive Behavior in Confinement, Washington, D.C.: American Psychological Association, 2002.

told me he fears he is getting paranoid and deteriorating. He attempted hanging again, and was transferred to observation at Auburn. The mental health staff told him he's not mentally ill and should not have medications.

Mental status examination: There was obvious tardive dyskinesia (involuntary movements due to brain damage secondary to taking older anti-psychotic medications for a long time) and tics; the prisoner scratched his arm as we talked, was very anxious, made no eye contact for a while and then looked straight into the interviewer's eye in somewhat inappropriate fashion. There was pressured speech and some flight of ideas. There was a thought disorder and some bizarreness, along with credible reports of auditory hallucinations.

Clinical chart: The chart corroborates the history T.J. presented. A 1/12/00 (second) admission note to CNYPC from Green Haven SHU reflects diagnosis Major Depression with Psychotic Features, a report of command hallucinations involved in suicide attempts since 1996, and medications Prozac 20 mg. per day and Zyprexa 15 mg. per day. During his next prison term, on 10/8/03, he was housed in a SHU-200 and admitted to OMH caseload for a suicide watch. He was then admitted (for the third time) to CNYPC on 12/4/03 for a serious suicide attempt. There, he was adjudged not to suffer from a serious mental illness, but to have a high score on Hare's Revised Psychopathy Checklist, by Dr. Michael Guariglia. He was placed on an outpatient Behavior Management Plan, his medications were discontinued, and then he was returned to SHU at Auburn on 12/31/03. He immediately evidenced suicidal behaviors, including having a noose around his neck, that were tagged "gestures" by staff. It seems he was denied medications, as per the plan, but was kept in observation because of ongoing suicidal behaviors and statements. The Behavior Management Plan states that if observation is required, amenities in observation will be less than in a SHU cell "so that the SHU environment will be preferable to patient" and that DOCS staff will be alerted that his behaviors are not due to mental illness. Following the inception of the plan, T.J. continued to cycle from SHU or Keeplock to Satellite Unit observation for suicidal behaviors, and continued to be denied medications per the Behavior Management Plan. On 4/9/04 his Mental Health Level was 1.

T.J. has a long history of serious mental illness, pre-dating incarceration and running through three prison terms. His self-harming and sometimes assaultive behaviors are related to that mental illness. Yet he has been given tickets for self-destructive acts, placed in SHU, cycled repeatedly from SHU to observation and back to SHU, been medicated and then denied medications, removed from the OMH caseload, and generally has been inadequately treated for SMI, leaving him vulnerable to

breakdown, disciplinary problems and transfer to SHU. A Behavior Management Plan was instituted, based on the incorrect notion that his unacceptable behaviors were willful bad acts and not due to mental illness. The elements of the plan described in the above case study– including denial of mental health treatment, punitive consignment to observation with reduced amenities, withholding of medications when he is in crisis – have caused T. J. intense distress and violate basic human rights and basic requirements of clinical practice and professional ethics.[94]

D. D. X. **(Interviewed while housed in observation at Great Meadow on 8/26/03).**

History: This man has been in prison since 1990. At the time of our interview, he had been in observation for several days; prior to that he was in SHU after receiving a ticket in ICP. He has been admitted to CNYPC 24 or 25 times, and prior to incarceration he was admitted to Kings County Hospital and other psychiatric facilities on several occasions with a diagnosis of Schizophrenia. He reported that during his last admission to CNYPC, approximately a year ago, after an assessment by Dr. John Wilson, "they said there's nothing wrong with me." He had been hearing voices telling him to do destructive things, but he hasn't heard any for the past couple of months. He feels he did better when he was in ICP. He has been prescribed Depacote, Risperdal, Zyprexa and other mood stabilizers and anti-psychotics. He discontinued his medications in April because CNYPC does not feel there is anything wrong with him – i.e., his pride pushes him to refuse treatment if they say there's nothing wrong with him. He reported that he listens to radio or t.v. in his cell, paces and sings. He does not read well (he left school in the sixth grade).

Mental status examination: He seemed agitated, with bizarre affect and behaviors, including some involuntary tics or compulsive movements such as head shaking. His speech was pressured. He denied auditory hallucinations but I observed enough internal preoccupation and bizarre gestures to be very skeptical about that; he clearly exhibited ideas of reference and strong First Rank Symptoms (predominantly thought insertion – signs of psychosis that are very difficult to feign). He intermittently stuttered and exhibited slurred speech, and he perseverated on the theme of his innocence. He was very concrete, unable to abstract, and had inappropriate affect. I observed his SHU cell, and there were many rolled-up pieces of paper wedged in the windows.

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[94] American Psychiatric Association, "The Principles of Medical Ethics with Annotations Especially Applicable to Psychiatry," 1995; Human Rights Watch, Ill-Equipped: U.S. Prisons and Offenders with Mental Illness, 2003.

Clinical chart: His larger-than-a-carton thick clinical chart begins with a 12/10/90 initial assessment reporting previous psychiatric hospitalizations and a diagnosis of Schizophrenia, Undifferentiated. His medications have included strong anti-psychotic and mood stabilizing agents (indicated for Bipolar Disorder or Schizoaffective Disorder) for most of the last twelve years, and now are Zyprexa 15 mg./day and Depakote 1000 mg./day – an anti-psychotic agent and a mood stabilizer, respectively. He has been in and out of CNYPC, observation, and ICP, back to at least 1994, when progress notes reflect that he could not manage in population but needed ICP, and other notes reflected that he received tickets and went to SHU, where his condition deteriorated and he "hung up" and had to go to CNYPC. At that time (1994), he was recognized to have a very disturbed presentation, which was diagnosed as organic brain problem with mental retardation, and his behavior was barely manageable when he was taking strong psychiatric medications and was provided a structured environment, the best being ICP. But then he was sent to SHU, where his condition deteriorated anew and he was re-admitted to observation and CNYPC. His admission diagnosis to CNYPC on 4/27/97 is Schizophrenia, Undifferentiated Type with Borderline Intellectual Functioning and ASPD. By 1999, his diagnosis was Impulse Control Disorder, but there was no explanation of what became of Schizophrenia, and he was continued on anti-psychotic and mood stabilizing medications that are indicated in the treatment of Schizophrenia and not Impulse Control Disorder. He was repeatedly placed on suicide watch in observation. Then, during an admission to CNYPC, Dr. John Wilson submitted a 39 page, single-spaced report of psychological testing at CNYPC on 7/10/02. The test results were confusing. Dr. Wilson found that J.D.X is in the lowest 1% on IQ tests, IQ in mid- to high-60's, and has been since childhood. Dr. Wilson diagnosed Mental Retardation. He also found organic brain dysfunction and diagnosed amnestic disorder. But then he found ASPD with possible differential of Rapid Cycling Bipolar Disorder, but found insufficient evidence for the latter. He recommended a Behavior Management Plan and recommended against future admissions to a psychiatric ward because that rewards bad behavior. After return to Great Meadow from CNYPC, J.D.X. medications were Zyprexa 20 mg. per day and Depakote 1500 mg./day – i.e., a dose of an anti-psychotic sufficient for the treatment of active psychosis and a dose of a mood-stabilizer adequate for the control of a Bipolar Disorder or Schizoaffective Disorder – and he was referred to ICP. He was in ICP from 9/02, and discharged on 5/21/03 for poor adjustment. He soon was in SHU and cycled to observation while refusing treatment because he believed staff at CNYPC did not believe he suffered from mental illness. An 8/10/04 update to his Core History noted " J.D.X is not able to read, write or concentrate. Testing has shown he is not able to remember more than 2 bits of data at a time. He misperceives

many situations, and reacts impulsively." On 8/5/04 he was re-admitted to CNYPC, the stated reason being that he was "disorganized and unpredictable," further: "HE IS ON OUTPATIENT BEHAVIOR MANAGEMENT PLAN. DISORGANIZED, HAS BEEN ACTING OUT, HAS BEEN IN SHU FOR A LONG PERIOD OF TIME YELLING, SCREAMING. HE IS EATING BUT HAS HAD PERIODS WHEN HE WOULDN'T EAT BECAUSE OF THE LOAF DIET." His admission diagnosis was "Psychotic Disorder NOS." By 8/17/04 – less than two weeks later - he had been discharged from CNYPC and returned to SHU. A 9/30/04 Outpatient Termination Note reflected a diagnosis of "none" on Axis I.

DDX is clearly suffering from psychosis, likely Schizophrenia, with a mood disorder, probably a co-occurring organic brain disorder, and Mental Retardation. He has been 'un-diagnosed' by Dr. Wilson at CNYPC after 24+ admissions. But even after he was "un-diagnosed" and precluded by the Behavior Management Plan from future admission to CNYPC, he was prescribed high dosages of anti-psychotic and mood-stabilizing medications. On 8/5/04 he was readmitted to CNYPC; contrary to the Behavior Management Plan it seems he was admitted because he was flagrantly psychotic and "disorganized." Thus, the Behavior Management Plan had delayed his admission to the psychiatric facility, causing unnecessary suffering.

OMH recognizes[95], and it is well known in the mental health professions, that a significant number of prisoners have co-occurring Axis I mental illness and Axis II personality disorders. There is some clinical research asserting that traditional mental health treatment does not work for individuals who score high on Hare's Revised Psychopathy Checklist.[96] **But there is a growing body of literature that exposes the errors in the "treatment-doesn't-work" approach.[97] In fact, with individuals who have co-occurring SMI and Antisocial Personality Disorder, especially those who score high on the Psychopathy Checklist (Psychopathy is not a diagnosis in DSM-IV, but ASPD is), intensive treatment of the symptoms of serious mental illness (psychotic hallucinations and delusions, severe depression, mania and so forth)**

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[95] Merrill Rotter, Bruce Way, Michael Steinbacher, Donald Sawyer & Hal Smith, "Personality Disorders in Prison: Aren't They All Antisocial?," Psychiatric Quarterly, Vo. 73, No. 4, 2002, pp. 337-349; see Miraglia Deposition, p. 238.

[96] Gacono, C., Nieberding, R., Owen, A., Rubel, J., & Bodholdt, R. (1997), "Treating conduct disorder, antisocial, and psychopathic personalities," in J. Ashford & B. Sales (Eds.), Treating adult and juvenile offenders with special needs (pp. 99–129). Washington, DC: American Psychological Association.

[97] Rice, M., Harris, G., & Cormier, C., "An evaluation of a maximum security therapeutic community for psychopaths and other mentally disordered offenders," Law and Human Behavior, 1992, 16,399–412; Gacono, C., Nieberding, R., Owen, A., Rubel, J., & Bodholdt, R., "Treating conduct disorder, antisocial, and psychopathic personalities," In J. Ashford & B. Sales (Eds.), Treating adult and juvenile offenders with special needs, American Psychological Association, 1997, pp. 99–129.

actually helps individuals take part in treatment and rehabilitation programs, and then they actually are much more treatment-responsive and cooperative than they would be were their serious mental illness not adequately treated.[98]

As I explained in the previous section, the serious error of the CNYPC Psychological Assessments and Behavior Management Plans that I reviewed in the cases I investigated in DOCS is that the CNYPC psychologists make it an either/or decision – either the person is a psychopath or there is serious mental illness. Again, this is that overly simplistic "mad-or-bad" logic that misses the complexity of the phenomenon. The logic of CNYPC's psychological assessment in the cases I have presented (E.E.M. T.J. D.D.X. as well as the case of T.R. that I presented earlier) and in many others I reviewed is that a prisoner who is disruptive and scores high on Hare's Revised Psychopathy Checklist must not be suffering from a serious mental illness; rather his or her unacceptable behaviors are reflections of willful disregard for the feelings of others and other psychopathic traits. Then, the psychologists accept uncritically and one-sidedly the part of the clinical/correctional literature that expresses pessimism about treatment prospects with psychopathic personalities, and concludes that these individuals should not be admitted to treatment programs because: 1. they have no Axis I diagnosis; and 2. their Axis II diagnosis, i.e. Psychopathy (or the DSM Axis II Antisocial Personality Disorder) makes them poor candidates for mental health treatment.

When clinicians decide in advance that a certain prisoner, were he to attempt to harm himself or exhibit frankly psychotic symptoms in the future, is not to be seen by a mental health clinician for a certain period of time, or is not to be admitted to a crisis intervention unit (observation) or a psychiatric hospital (CNYPC), then these clinicians are committing very poor clinical practice that falls well beneath the standard of care in the community, and they are in violation of ethical standards that require the clinician to treat a person who is suffering from an illness. In other words, they are withholding treatment. It is not a clinically nor ethically sound practice to determine in advance that particular individuals are to be denied certain treatments in the future even if they develop signs of an illness that requires that kind of treatment. How can a clinician preclude the kind of open-minded re-assessment that should be done when a new crisis arises by ordering that the clinician should not even see the patient for at least a day when the new crisis occurs? In more than a few cases in DOCS, the assumptions underlying Behavior Management Plans were actually disproved by subsequent events – e.g. someone who was diagnosed "no Axis I diagnosis" and put on a plan was subsequently re-assessed and it was decided the individual was psychotic enough or depressed and suicidal enough to admit him to CNYPC.

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[98] Jennifer L. Skeem, John Monahan, and Edward P. Mulvey, "Psychopathy, Treatment Involvement, and Subsequent Violence Among Civil Psychiatric Patients," Law and Human Behavior, Vol. 26, No. 6, December 2002; Salekin, R., "Psychopathy and therapeutic pessimism: Clinical lore or clinical reality?," Clinical Psychology Review,22, 2002, 79–112.

It is not permissible to place someone in a treatment setting such as observation in the Satellite Mental Health Unit, and purposely design that form of treatment to be so noxious that the person will not want to go there. Even if one were to give the designers of Behavior Management Plans the benefit of the doubt, and assume that their instructions to make observation more uncomfortable than a prisoner's SHU cell is motivated by an interest in treating the prisoner's dysfunctional behavior, this is a very ineffective treatment strategy and the conditions it imposes on the prisoner are degrading. Forcing a prisoner to eat cold "loaf" as discipline because he dared to cut himself or try to hang himself falls beneath current standards of human conduct, not to mention standards of professional practice and ethics. Likewise, keeping a patient who has been depressed and suicidal in an observation cell where he is naked except for a gown for weeks at a time, and not admitting him to a psychiatric hospital where he can receive proper treatment, is simply beneath all standards.

b. Proposed Behavioral Health Units (BHU)

The 2004-2005 Executive Budget Forensic Mental Health Initiatives (Plaintiff's Exhibit 238, 5/26/04) states:

> "OMH is proposing the establishment of two Behavioral Health Units (BHUs), which will serve as an alternative to SHU placement. This program will provide services to inmates with serious mental illness who, due to their level of violence and disciplinary infractions would typically be housed in SHUs. These are inmates who have displayed a marked inability to conform their behavior to societal or institutional standards of conduct. Short of inpatient commitment to CNYPC, the BHU represents the most intense level of mental health services provided to inmates prone to disciplinary infractions. The major component of the program is specialized management and treatment, and the program will employ behavioral management and cognitive-behavioral interventions."

I have reviewed the 2005 Draft proposals for Behavioral Health Units, Phase I to encompass 38 beds at Great Meadow and Phase 2 and 3 to encompass 32 beds each at Sullivan. My greatest concern about this development is that the Behavioral Health Units will follow, in philosophy as well as in practice, the wrong direction pursued in the Behavior Management Plans just discussed. OMH urgently needs a well-thought out approach to the "disturbed/disruptive" prisoner. The proposal for the Behavioral Health Units seem to be an attempt to solve this problem, and it contains some good ideas. It also has some very big flaws built in at the initial stage of planning.

From my review of the proposals, I believe that the BHU is a phase program, in which prisoners with serious mental illness and disciplinary problems will be rewarded with more amenities and privileges as they demonstrate that they have learned to behave appropriately. The most significant problem with this kind of phase program in a correctional setting is that individuals suffering from serious mental illness tend to get stuck in the lowest phase, or cycle back to the lowest phase after they have reached a

higher phase, because the symptoms of their mental illness prevent them from achieving the required tasks, or get them into disciplinary difficulties that will bump them back to the lowest phase.

In this context, it is a concern that in the documents I reviewed, time frames are not applied to the various phases. Phase one is the most restrictive phase, and requires the prisoner to demonstrate good behavior. This is a set-up for failure in that a prisoner with serious mental illness will likely fail because the very restrictive environment will cause him or her to misbehave or be incapable of achieving what is required to pass on to the next phase. This problem needs to be resolved by lessening the restrictiveness of the setting, offering incremental rewards for small accomplishments, and providing professional staff support to the prisoner with serious mental illness throughout the process. Then, as a limiting factor, there needs to be a tracking and flagging system in place, so that if the phase is designed for thirty days and a prisoner is not able to achieve advancement to the next phase in (to provide an example, 45 days), that failure should trigger an automatic psychiatric assessment and the devising of an individualized treatment plan to help that individual advance to the next phase.

The disciplinary system, as outlined in the proposals, is flawed. A dual disciplinary system is envisioned. The subgroup of BHU prisoners who do not cause too serious of a problem will be disciplined by a collaborative team of mental health and security staff within the BHU; but the subgroup of BHU prisoners who cause too much trouble is immediately turned over to DOCS to be disciplined. This is going to re-create the kind of dual-track system that exists already: the "good" patient with SMI is welcome in ICP, but the "bad" patient who gets a Tier 3 ticket is ejected from ICP and has to go to SHU. The kind of dual-track system contained in the BHU proposals is going to lead to transfer for a subgroup of disturbed prisoners from Behavioral Health Units to SHU. Instead, there needs to be a self-contained disciplinary process within the Behavioral Health Units, so that the staff in those units can deal with the entire range of behaviors that set off disciplinary sanctions. In addition, there needs to be a policy that prevents return from the BHU to SHU. Once a prisoner begins to take part in the BHU, he needs to be kept out of SHU.

Finally, the proposals I reviewed do not offer any intensive mental health treatment. I see rehabilitation and education efforts, and various kinds of growth experiences. But if the population is composed of prisoners who suffer from serious mental illness, there need to be psychiatrists, psychologists, psychotherapy opportunities, and psychiatric rehabilitation programs, and this is just not visible in the proposals.

4. Prescribing Practices and Record-Keeping

Great advances have been made in psychopharmacology. Lithium, the prototype for a line of "mood-stabilizing" medications, was made available for routine prescribing in the early 1970s. Pharmacologic treatment for Bipolar Disorder became much more effective, and since then a variety of equivalent "mood-stabilizing" medications,

including Tegretol, Depacote, and Lamictal, have become available. Prozac arrived in the late 1980s, and there followed a series of Selective Serotonin Reuptake Inhibitors and other classes of newer antidepressant agents that are more effective than the old-line antidepressants, and much less toxic. And a new generation of "atypical" anti-psychotic medications, beginning with Clozaril in the early 1990s, followed by Zyprexa, Risperdal, Seroquel, Geodon and Abilify, has made the treatment of Schizophrenia and other psychotic conditions much more effective. We are in a new age of psychopharmacology, and it is possible to prescribe relatively safer and more effective chemical agents than the ones that were available prior to the advent of Lithium.

But medications alone are not an adequate treatment for most varieties of mental illness, especially if the patient has to spend a significant part of each day in a prison cell. Research shows that medications are most effective when administered concurrently with one or another version of psychotherapy or psychiatric rehabilitation. Psychiatric medications are not a substitute for other forms of treatment; rather, they are an effective adjunct to other forms of treatment.[99] When medications are prescribed to someone who has little or no opportunity for meaningful talk with mental health clinicians, then the medications serve little purpose other than sedation. In my review of clinical charts, I found that there was often no clear rationale documented for the prescribing of psychiatric medications. Medications or their dosages would be changed with no progress note reflecting the clinical strategy of the physicians or psychiatrist ordering the change.

Psychotropic medications can have very serious and potentially toxic or fatal side effects. Periodic blood and urine laboratory tests are required to safely administer many of the psychiatric medications. I did not see appropriate blood tests reflected in the clinical charts. For example, patients being prescribed Lithium, Depacote and other mood-stabilizers need to have regular blood tests to determine if the level is in the therapeutic range, and if it has reached toxicity. In addition, most psychiatric medications require periodic blood tests for toxicity, which means testing liver and kidney function among other things. Mostly these tests were not in the charts I reviewed, or the lab tests were inconsistent or inadequate, placing prisoners/patients at risk of serious physical harm.

An 8/16/02 Memorandum from Zebulon Taintor, a member of the Board of Directors of the New York County Medical Society ,[100] to "Hal (Smith?) and Bill" mirrors my concerns here. It is a report of this clinician's findings at Attica Correctional Facility, and states: "I saw many patients (42 one day) and found, as the OMH Pharmacy and Therapeutics Committee has noted in most facilities, a large number of patients

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[99] Kupers, Terry. "Medications: Alternative or Adjunct to Psychotherapy?," in Public Therapy: The Practice of Psychotherapy in the Public Mental Health Clinic, Free Press, 1981, pp. 61-79.

[100] OMHCNY 082430-31.

receiving Valproic Acid or Divalproex (Depakene, Depakote). In only two patients were there blood levels in the therapeutic range... In most patients the most recent blood levels were from 1999 and 2000, often below the therapeutic range at that time with no dose change since.... I assumed that most of the patients had no therapeutic levels. They didn't know why they were on the medication and I usually could find no indication in the chart for using valproic acid..... Staff tell me there is only one phlebotomist in the facility and they had been told psychiatric patient blood would be taken on a 'resources available' basis...." Regarding the fact that notes of non-psychiatric medical treatment are not in the chart, Mr. Taintor states: "There is a great risk of potentially harmful (drug) interactions with two sets of physicians writing orders without each knowing what the other is doing." He also found some psycho-educational materials for patients on drug side effects, but noted that "there seems to be nothing on the mental illnesses."

Mr. Taintor's memorandum mirrors my findings: Laboratory tests are erratic at best, and often absent from the clinical charts; findings of lab tests that indicate toxicity or an insufficient dosage of medication are not followed up with indicated changes in the medication regimen, and contact between OMH staff and patients is too sporadic and superficial in many cases for effective psycho-education about the mental illness and the medications to take place. The failures with respect to laboratory tests result in at least two major problems: the patient is not receiving a high enough dose of the medication to attain therapeutic efficacy, or toxic levels of the medication are not detected and the patient can suffer liver failure and other disastrous side effects.

I noticed in the clinical charts that Clozaril is not prescribed often by OMH psychiatrists. Clozaril was the first of a line of newer, "atypical" antipsychotic medications that evolved in the 1990s with important therapeutic benefits for severely disturbed patients. Newer medications such as Zyprexa and Risperdal accomplish almost as much, but there are cases where Clozaril might prove more effective. The problem is that it has some serious, and potentially lethal, side effects if its administration is not monitored carefully. For example, one side effect is leukopenia or a low white blood cell count, which can obstruct immune response and potentially lead to death from infection. I believe that there are cases in a correctional setting where Clozaril is the medication of choice. But I am extremely hesitant to recommend its use in NY DOCS because of the problems I have discussed in the OMH mental health treatment delivery system. If rigorous monitoring of blood tests is not done, if careful notes including treatment plans and lab tests are not kept up to date in the charts, and if clinicians do not spend enough time with their patients to foster a healthy therapeutic relationship, then the prescribing of Clozaril can be very dangerous. I will stop short of recommending its prescription in NY DOCS, hoping that the other problems I have described will be ameliorated so that it will eventually make sense to recommend the use of Clozaril in very rare cases of psychosis where other anti-psychotic medications are not effective.

Typically a psychiatrist should see the patient who is taking psychiatric medications on a monthly basis or more often, talk to the patient about his condition and

the positive and negative effects of the medications, order the appropriate laboratory tests, and note in the chart the medications the patient is taking, any changes in the patient's condition, any side effects of the medications, any troubling laboratory results, and then, after completing the above steps, revise or reaffirm the treatment plan, including the rationale for the medications and the non-medication aspects of the patient's treatment plan. If the prisoner is known by past history to suffer from a serious mental illness such as Bipolar Disorder or Schizophrenia, and that prisoner is not taking psychotropic medications for some reason, there still needs to be periodic reassessments by a psychiatrist with the option of commencing psychopharmacologic treatment at an appropriate time.

In too many of the cases I reviewed in NY DOCS, the psychiatrist sees the patient for a few minutes at cell-front on a very irregular basis; and does not put an adequate note in the clinical chart explaining the treatment plan and the part that is played by the medications. This is an entirely unacceptable practice, and violates all standards of care in the community as well as in corrections, and places prisoners at risk because it involves a lack of adequate monitoring as well as ineffective treatment. Then, in quite a few cases, the clinical notes reflect a changed diagnosis, for example the prisoner who had been diagnosed Schizophrenic is now diagnosed "Adjustment Disorder" or "no diagnosis on Axis I," but the psychiatric medications that would be appropriate for the Schizophrenic condition are renewed, with no explanation of reasons for giving a strong anti-psychotic or mood-stabilizing medication to someone who is no longer diagnosed with the relevant mental illness.

E.U. **(Interviewed while housed at Clinton on 7/15/03.)**

History: E.U. informed me he had been in observation twice, was at CNYPC in October, 2002, has not been in SHU, and does not get disciplinary tickets. He took psychiatric medications for nine years, but when he arrived at Clinton the psychiatrist discontinued his medications. As soon as the medications were discontinued he became agitated and had trouble sleeping. He sent a written request to the psychiatrist to re-initiate medications and for a long time received no response, but five days prior to our tour she called him in and prescribed a liquid medication for sleep. She did not tell him what the medication was and did not discuss side effects with him. He reported that he has been staying in his cell all the time, seven days a week, he feels depressed most of the time, he does not have the initiative to do anything, does not talk to others, and does not read or write.

Mental status examination: This man was depressed, flat, concrete, exhibited marked psychomotor retardation, presented obvious anhedonia.

> **Clinical chart:** There are several diagnoses of Schizoaffective Disorder, depression, and psychosis NOS. When he entered Clinton in 7/03, he was seen by OMH for "voices and depressed." Throughout his chart there are reports of auditory hallucinations. It seems the psychiatrist at Clinton discontinued his psychiatric medications for no recorded reason, and there is no treatment plan.

Not only is a clinical rationale for medication prescribing absent from clinical charts, it is often the case that a patient fails to show up at an appointment to have the medications evaluated and possibly renewed, and then he or she is dropped from the OMH caseload for failing the appointment(s). If a prisoner who is known to be suffering from serious mental illness decides to discontinue taking his or her medications for any reason, and the staff do not feel that Medication Over Objection is indicated, it is not an acceptable practice to simply discharge that patient from the OMH caseload. In an institution like a prison, it is the responsibility of the mental health professional staff to follow prisoners known to suffer from serious mental illness.[101] The psychiatrist should continue seeing the individual, even though he or she has chosen not to comply with medications recommended. That way, the psychiatrist can assess the clinical situation on an ongoing basis, and it might turn out, for example, that at a later time the patient's condition deteriorates dramatically and he or she requires emergency assessment and hospitalization. Or, what is more likely, and the more desired outcome is, the fact that the psychiatrist has a relationship with the individual makes the individual more likely to trust the psychiatrist and start to ask questions about the medications, eventually deciding to take the medications that are indicated.

Record-keeping, specifically clinical chart notes, are not adequate. I have described the problem in relation to medication prescribing and laboratory tests required to monitor medication prescribing. Clinical chart notes are inconsistent. Treatment plans are often lacking. Changes are made in the treatment regimen, or prisoners are discharged from treatment or from a component program such as observation, and there are not sufficient notes in the chart to permit the reader to understand why the prisoner was discharged, nor what follow-up plan there is.

5. Medication Over Objection

The Rivers v. Katz decision[102] requires the state of New York to show, by clear and convincing evidence, that a patient that the state seeks to medicate over objection is incapable of making treatment decisions, and if so, whether medication will benefit the patient, and no less intrusive alternatives to forcing medications exists. (The court

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[101] Dr. Donald Sawyer testified that it is the plan of OMH to keep prisoners who have been Mental Health Level 1 on the OMH caseload for the remainder of their term in DOCS, even if they do not comply with treatment – but this plan is not always active (See Sawyer Deposition, pp. 216-217).

[102] Rivers v. Katz, 67NY2d 485(1986).

acknowledged that the state's police power justifies forced medications under emergency circumstances, so long as the emergency persists.) The factors involved in the contemporary discussion of involuntary medications in psychiatry are quite complex. On one hand, there is the patient's right to choose to undergo treatment and to be free of unnecessary coercion; on the other hand there is the interest of the social unit (in this case the correctional system) in controlling unacceptable behaviors. Research shows that where there are adequate mental health services – i.e. in service delivery systems where clinicians have sufficient time to form a trusting relationship with patients and patients can look forward to seeing the same provider on successive visits – there is relatively little need for involuntary medication of any kind; on the other hand, where mental health services are reduced substantially by budget cuts and staff shortages, the staff are overburdened and are not able to take the time to establish trusting relationships with patients, clinicians more often feel they have to resort to involuntary medications. Such is the case in New York. In California, when the state legislature debated a new law a few years ago that would make it much easier for psychiatrists to order involuntary medications beyond the rare emergency situation, wording was introduced that required counties that wished to enact the new involuntary medication capability to also bolster their public mental health services – in other words, the logic is that if they first make a concerted effort to provide adequate services, they will not need to utilize the involuntary medication statute except in very rare and extreme cases.

In response to the Rivers decision, OMH promulgated regulations which require that the patient be involuntarily committed to a psychiatric hospital before non-emergency medication may be forcibly administered. In addition, there must first be administrative proceedings and there is a right to a court review, if appealed.[103]

OMH now allows for an exception to this rule. There are now "traveling Rivers orders," i.e. court orders for involuntary medication that continue to be in effect after the patient is transferred from the designated inpatient setting to a Satellite Mental Health Unit, and then to any housing unit in a designated correctional facility. The prison designation seems to depend on the staff in that facility receiving training in the implementation of "traveling Rivers orders." According to Dr. Don Sawyer (Deposition, pp. 474-486), while OMH would prefer that prisoners with traveling Rivers Orders receive involuntary medications only within the Satellite Mental Health Unit or SHU housing with an STP at designated facilities, in fact there are prisoners for whom OMH has traveling Rivers orders who are housed in SHU without STP participation. There is no formal review procedure in place to prevent abuses of the process.

Traveling Rivers orders are very problematic. I have described problem after problem in the delivery of mental health treatment to the large population in need within DOCS. A large number of prisoners are relegated to isolated confinement (SHU and Keeplock), mental health services in isolated confinement settings is far from adequate,

[103] 14 NYCRR Section 27.8.

confidentiality is lacking, crisis intervention in observation cells within the Satellite Mental Health Units is more punitive than therapeutic, and the conditions of confinement in observation are more harsh even than in SHU, and so forth (as set forth above). I have pointed out major deficiencies in prescribing practices. In my opinion, traveling Rivers orders would be problematic in any correctional setting – there is good reason why involuntary medication is required to occur only in inpatient settings or settings with an equivalent level of mental health treatment – but in NY DOCS, where the many deficiencies and abuses I have delineated prevail, permitting traveling Rivers orders will in many cases lead to the warehousing of prisoners in a SHU cell, where their hallucinations and despair will be intensified, and then using force to pull them out of their cell to give them an unwanted injection of medications that might put them to sleep, but will not correct the causes of their psychotic regression and despair.

Thus, this policy of long-term forced medication orders in the outpatient setting, where mental health services are inadequate (as described in my report), means that prisoners are not only denied the mental health treatment their condition requires, they are also subjected to further indignities, including the utilization of physical force in the process of administering the medications. There is risk of physical harm.

6. Staff Training and Collaboration between Mental Health and Security Staff

I had an opportunity to review several training protocols, including training on mental health for SHU staff, training about disciplinary procedures following the settlement of Anderson, and training in suicide prevention. I have not had an opportunity to thoroughly assess the amount of training that mental health staff and security staff actually undergo. Often in a correctional system there are training materials available, and a decision is made by managers in good faith to conduct training for all staff, but then the actual implementation of the training program does not meet desired expectations. For example, the 1995 training manual on suicide preventions cautions staff not to over-utilize the notion of malingering and not to relax their guard in preventing suicide risk in prisoners perceived as manipulative, but still staff tend to dismiss reports of suicide ideation on the part of prisoners they consider manipulative. I have seen some other indications that staff training within DOCS and OMH is inadequate. For example, Dr. DeVito testified that there is a need for more training for DOCS staff about mental health issues (DeVito Deposition, p. 51 & p. 131); Dr. Shimkunas testified that the eight-hour suicide training for DOCS staff had not been done for a couple of years, and currently DOCS staff receive only one and a half hours training per year about suicide (Shimkunas Deposition, p. 200); Richard Miraglia testified that not enough clinicians in OMH have been trained in the Psychopathy Checklist assessment to meet the clinical need (Miraglia Deposition, p. 233-234). Thus, improvements in the training for both DOCS and OMH staff are needed, as is recognized by OMH managers.

But there is a better method for assessing the adequacy of training, and that is by investigating the actual practices of staff, both security and mental health staff. Throughout this report I have provided evidence of deficient and destructive practices on the part of both DOCS security staff and OMH staff. For example, consider the actual practices I discovered regarding prisoners who present a risk of suicide. There is confinement under harsh conditions in observation, failure to send seriously suicidal individuals to CNYPC for inpatient treatment, cell-front and non-confidential meetings between OMH staff and prisoners in observation, poor prescribing practices, a lack of treatment plans in the clinical charts, and a tendency to incorrectly dismiss prisoners' reports of suicidal ideation and intentions as manipulations and malingering.

From these observations, I have come to the conclusion that training in suicide prevention and crisis intervention, for both security and mental health staff, is grossly deficient. In other words, were there adequate training regarding suicide prevention and crisis intervention, better treatment would be afforded prisoners who present a serious risk of suicide, and staff would have a more caring attitude toward prisoners suffering from serious mental illness. Similarly, complaints of emotional pain on the part of prisoners with SMI in isolated confinement are ignored or diminished by both security and OMH staff. This leads me to conclude that training for security staff about mental illness and training for OMH staff about the psychological effects of isolated confinement and assessment for malingering are grossly deficient.

In general, I conclude from the deficiencies and unacceptable practices that I have described in this report that there needs to be more and better training for security staff about mental illness, its identification and treatment, the extent of past trauma in the lives of prisoners, gender sensitivity, and so forth. And from my investigation of practices and cases, I have arrived at the conclusion that OMH staff need more and better training about the life experiences of prisoners, the importance of trauma in their lives, the effects of conditions of confinement, the importance of confidentiality, the techniques of clinical assessment of prisoners, the proper format for clinical record-keeping, and psychopharmacology and prescribing practices. In fact, there is not enough cross-training, i.e. training of security staff regarding mental health issues and training of OMH staff about security issues.

Similarly, close collaboration between security and mental health staff is essential in a corrections system if prisoners with serious mental illness are to be properly managed and treated. The problems I have pointed out throughout this report reflect a lack of adequate collaboration between security and mental health staff. The most obvious example is the failure of OMH staff to intervene adequately in disciplinary matters when the behaviors that are to be punished are possibly driven by mental illness. But there are other reflections of poor collaboration. The culture of security is a given in correctional settings. The security staff has the very difficult job of maintaining order and fostering the smooth operation of the facility. Of course, mental health staff must collaborate closely with security staff in order to safely engage in treatment while not interfering with

operations. However, when mental health staff becomes taken over by the culture of security to the extent that they forfeit their independent clinical stance, treatment is greatly compromised. When a large proportion of prisoners are plagued by serious mental illness and require treatment, a certain degree of tension between security concerns and treatment concerns should be an integral and appropriate part of staff relations. Working through and resolving this kind of tension is a critical ingredient in productive collaboration.

To the extent mental health staff succumb to the culture of security and, for example, over-utilize diagnoses such as malingering or ignore prisoners' reports of emotional pain and despair, the prisoner who suffers from mental illness and breaks rules tends to be punished harshly instead of receiving urgently needed treatment. When prisoners with serious mental illness are disruptive, there needs to be a collaborative intervention by security and mental health staff. Where such collaboration is effective, there is much less need for "use of force" and other punishments, and security staff serve to direct mental health staff to cases requiring more intensive intervention.

7. Use of Force on Prisoners with Serious Mental Illness

Many prisoners suffering from serious mental illness told me in graphic terms about having been subjected the use of force by staff. I also had an opportunity to view videotapes of "take-downs," "cell extractions" and other uses of force. The videotapes I viewed involve prisoners YB 5/21/03; YH 11/10/04; PN 10/26/96, Attica, move to B-North; VO 6/21/03; K.K. 7/25/94; and T.F.Z. 3/5/00.

It is quite painful to watch the 5/21/03 "take-down" of YB YB has been taken to observation, she is being held down on the floor by and stripped naked by several officers using scissors to cut away her clothes. She is screaming and crying the entire time (approximately ten minutes on the videotape). Mostly the officers hold her face down on the floor and do not talk to her nor reassure her until the end of the tape when one says "Relax, we'll be out of here in a second." VO is also subjected to a strip search in observation. Her clothes are torn off as several officers hold her down on the floor. She is relatively quiet, she wears a "spit mask," they perform a cavity search, there is joking in the background and at certain points one or more male officers is present while she is naked.

E.R. an inmate housed in SHU at Bedford Hills Correctional Facility, testified that the first time she was brought to observation she did not understand that she would be subject to a strip search, and the process increased her agitation. She was then forcibly and brutally stripped and left naked in her observation cell, while male correctional officers were present. She has observed other prisoners naked in their observation cells as well. (E.R. deposition, pp. 61-65).

I mentioned in my discussion of N.A. (Section V) that a majority of women in NY DOCS had been traumatized – physically and sexually abused – prior to incarceration, and that experiences in prison such as confinement in SHU can replicate past traumas or constitute "re-traumatization." Searches by male officers can be an extremely traumatic experience for imprisoned women, as many I interviewed told me. The videos confirm their reports. When staff speak in demeaning ways to women, handle them roughly, and violate their boundaries (in the process of a "take down" or search), the women suffer great emotional harm, and when they suffer from serious mental illness, it is likely the re-traumatization will worsen their illness, their disability, and their prognosis. Greater sensitivity to these issues on the part of staff is urgently needed.

In another video I reviewed, YH becomes quite emotional when officers tell him that they are confiscating his address book as "contraband." He screams and cries, stating that they are taking away his family. He appears increasingly regressed and paranoid as he gets excited, and an officer tells him to "calm the fuck down," and to "stop feeling sorry for yourself." They take him to observation, forcibly remove his clothing when he seems unable, and all the while he is becoming increasingly paranoid, accusing them of poisoning his food and so forth.

PN , who suffered from serious mental illness and eventually killed himself in DOCS, was also shown on video being treated harshly and insulted as he was searched and transported to observation. K.K. is forcibly removed from his cell after being "gassed." He is beaten numerous times with a club, even after he is on the floor. He is treated brutally, and even though he is on the OMH caseload, there does not appear to be any OMH staff present during the cell extraction, and transfer of this patient to the hospital. By the end of the videotape he has been stood on his feet; he collapsed, and he appears to have suffered a seizure. F.F.Z. has been "gassed" (i.e. subjected to an immobilizing gas), forcibly removed from his cell, and is strip searched (off camera) after a video-taped interview with a nurse wherein he makes some comments that might reflect psychiatric illness (e.g. "I always kill my enemies"). The nurse tells him she cannot help him with his "security-related" problems, and leaves the room. He is put in an observation cell. Many of the prisoners I interviewed are terrified of the expectable use of overwhelming force by staff.[104]

When a prisoner who is suffering from mental illness is subjected to the use of force, there are likely to be these predictable ramifications: in all prisoners, an exacerbation of fear and anxiety; in a prisoner prone to paranoia, intensified paranoia; in a prisoner prone to depression and self-harm, an intensification of the depression and increased likelihood of suicide; in a prisoner prone to extreme mood swings, an increase in the extremity of their depressive and manic swings, or in their frequency. Further, in prisoners prone to Posttraumatic Stress Disorder (PTSD) or suffering from PTSD related to prior traumas, a cell extraction or an incident

[104] Donald Sawyer testified that, generally, an OMH staff member is not required to be present during strip frisks of patients. (See Sawyer Deposition, pp. 197-199.)

involving use of an incapacitating gas, or other use of force, is experienced as a re-traumatization and the PTSD becomes more severe and chronic. And in a prisoner suffering from severe mental illness who is prone to act out his anxiety and other psychiatric symptoms by resorting to hyper-masculine bravado, there is an exaggeration of that tendency, and this can lead to further use of force by officers.

Many prisoners with serious mental illness in SHU spoke about the use of force by officers, including the use of immobilizing gas, physical cell extraction and forcible strip searches. I am not in a position to judge the veracity of every report, nor did I do the kind of investigation that would be required to assess the necessity of force in each case or whether the force used was excessive. The point is that prisoners with serious mental illness are strongly affected by the use of force, but use of force is much more likely to occur in maximum security prisons, and especially in SHU. Thus, the fact that DOCS and OMH move prisoners from lower security facilities to maximum security facilities because the Satellite Units are located in the maximum security facilities, and the fact that DOCS and OMH consign a disproportionately large number of prisoners with serious mental illness to SHU, means that prisoners suffering from serious mental illness are at greater risk of being on the receiving end of use of force by security staff than needs to be the case, and that, as I have shown, use of force can be very destructive for them.

8. Post-Release Planning

There is some much needed attention to post-release planning. Some of the substance abuse programs available in DOCS have continuation components for post-release consumers. And at Sing Sing Correctional Facility I toured the Community Orientations and Re-Entry Program (CORP), a post-release preparedness-training for prisoners with mental illness who are within 90 days of the end of their prison term. I toured the CORP program on 5/7/03, and it had just been opened. There were seven prisoners in the program at that time, but the capacity is 31. The July 15,2004 "Report on Outpatient Mental Health Services Provided by CNYPC in NYS Prisons in 2003" by R. Beer and B. Way reflect the same basic picture: the average number of CORP patients at the end of each month in 2003 was 15. I met with the CORP staff, who explained the intensive groups they provide, including anger management, psycho-education about mental illness and its treatment, and medications group. The staff seemed enthusiastic and optimistic about the program's prospects for helping released individuals succeed in the community. The only problems with this encouraging program are its small size relative to the large number of prisoners who are released from DOCS, and the fact that the CORP program occupied a section of the ICP unit. In other words, the beds in the CORP program were from the ICP program, and as I explain elsewhere, more ICP beds are needed.

A very large problem for prisoners suffering from serious mental illness is that they spend a significant length of time in SHU, and then they are released to the community directly from SHU, with no post-release preparation to speak of and no

opportunity to get used to being with people again after the lengthy period of isolated confinement. This is a recipe for disaster. An example is E.R. a prisoner in SHU at Bedford Hills, who was deposed in this case on February 17, 2005, while serving a three year sentence in SHU. Her release date was March 14, 2005, and at the time of her deposition it appeared she was scheduled to be released to the community straight out of the Bedford Hills SHU. E.R. who is literate (in contrast to many other prisoners with mental illness), learned of programs in the community by reading a Fortune Society newsletter, and tried to follow through, but received much less help from OMH than she needed (and this deficiency is much worse for prisoners with limited reading and writing ability). (See E.R. deposition, pp. 54-59).

VII. How New York's Prisons Compare with National Trends

New York DOCS and OMH pride themselves on offering a full range of mental health services to individuals confined in NY DOCS. And, indeed, there are many aspects of the mental health services that deserve praise. For example, as I have reported, I am impressed by the psychiatric hospital at CNYPC and the ICPs – in spite of ongoing problems, these are quality programs and should be expanded. CORPS, the pre-release program at Sing Sing, is admirable, even though it is too small to handle the need and it occupied a unit that would otherwise serve as an ICP and thus its development made the shortage of ICP beds even worse – pre-release programming should be expanded, but this should occur concurrently with the expansion of ICP programming and not at the expense of ICP beds. These components of the mental health services OMH offers to DOCS patients are comparable to some of the best mental health programs in the nation. According to the Bureau of Justice Statistics, 13% of State inmates were receiving mental health therapy and 10% were receiving psychotropic medications in 2000.[105] New York's figures are approximately average.

But there are some areas where NY DOCS and OMH fall well beneath the standard and precedent being set in other parts of the country. The most glaring example is the large number of prisoners suffering from serious mental illness who spend an inordinately long time in isolated confinement.

New York places a relatively large proportion of its prison population in isolated confinement. Sometimes it is difficult to compare practices across the states in this regard because the various states report different kinds of figures, some combining administrative segregation while some keep them separate, some counting very short-term isolation and some not, etc. But I will make my best effort to accurately reflect relative population sizes in different states. According to the Corrections Yearbook 2001, between 1994 and 2001 the average percentage of prisoners in segregation and protective

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[105] Beck, Alan, Special Report: Mental Health Treatment in State Prisons, 2000, U.S. Dept. of Justice, BJS, available at www.ojp.usdoj.gov/bjs/.

custody increased from 4.5 percent to 6.5 percent.[106] According to a Human Rights Watch report, nationwide, New York's reported 7.8% in segregation (SHU and Keeplock) is well above the average for the 36 states reporting on the number of prisoners in segregation.[107] California and Texas, two states that pioneered the use of isolated confinement units, house between 3% and 6% of their prison populations in isolated confinement. Washington State, another pioneer in the use of isolated confinement, houses less than 2% of its prison population in isolated confinement units. In addition, in comparison to other states, the length of stay for prisoners in NY DOCS SHUs exceeds that in other states.[108]

Besides subjecting a relatively large proportion of its prison population to isolated confinement, NY DOCS selectively consigns a relatively large proportion of prisoners with SMI to isolated confinement. Many states exclude prisoners with serious mental illness from long-term isolated confinement. Litigation has led to the exclusion of prisoners with serious mental illness from long-term isolated confinement in California, Wisconsin, Texas, Connecticut, New Mexico, and Ohio. Illinois DOC, by policy, excludes prisoners with serious mental illness from the isolated confinement unit, Tamms. Even states that do not exclude prisoners with serious mental illness from isolated confinement report, on average, that approximately 12% of the prisoners in isolated confinement suffer from serious mental illness. New York DOCS and OMH report that the proportion of prisoners in SHU and Keeplock suffering from serious mental illness is far above that national average, with as many as 64% of prisoners in SHU in maximum security facilities on the OMH caseload. Remarkably, Harold Smith, Executive Director of CNYPC, testified in his deposition that he did not know that there were states that exclude prisoners with serious mental illness from isolated confinement. (See Smith deposition, pp. 405-406).[109]

In some other states, isolated confinement is not designed mainly as punishment, rather it is a time-limited program designed to alter behavior so that prisoners can control themselves and return to general population. I have met with the Mental Health Director of the Departments of Corrections in New Mexico and Connecticut, respectively, and worked out improvements in their plans to return prisoners to general population. The state of Washington DOC makes clear that the purpose of its isolated confinement units is to help prisoners change their behavior so they can cope better in general population. In these states, as well as Wisconsin, if a prisoner does not proceed as expected through the

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[106] Camp, C.G. & Camp, G.M., Corrections Yearbook 2001: Adult Systems, Connecticut: Criminal Justice Institute, 2002, p. 38.

[107] Human Rights Watch, Ill-Equipped: U.S. Prisons and Offenders with Mental Illness, New York: Human Rights Watch, 2003.

[108] Correctional Association of New York, "Mental Health in the House of Corrections," June, 2004.

[109] Richard Miraglia, Assistant Commissioner of Forensic Services for OMH, testified that he was aware of settlements in a number of other states that exclude prisoners with serious mental illness from isolated confinement. (See Miraglia deposition, pp. 140-143).

phases of a program where the eventual goal is return to general population, then the mental health staff initiates rigorous mental health assessments to see if symptoms of a mental illness might be causing the prisoner to fail to advance through the phases of the program. This is a stark contrast to NY DOCS, where prisoners with serious mental illness quite routinely accumulate additional disciplinary tickets after they are transferred to SHU, and very little is done to correct this unfortunate pattern. In states that design their isolated confinement units to be a time-limited effort to teach prisoners skills they will need to cope in general population or in the community after they are released, the guiding idea is that prison is the punishment determined for a crime by the courts while isolated confinement is merely a means to help the prisoner adjust to the prison environment so he or she can safely serve the sentence without disrupting institutional operations. This in contrast to New York DOCS, where punishment in addition to the prison term is the stated aim of SHU and Keeplock confinement.[110]

Some states are closing their isolated confinement units or converting them to other purposes – Michigan's Ionia Max no longer serves as an isolated confinement facility, and Maryland has announced the state is closing its isolated confinement prison. Virginia had two facilities dedicated to isolated confinement, but that state is converting these facilities to "regular" maximum security prisons, thus reducing the state's isolated confinement capacity by more than 75%.

The routine in isolated confinement cells in NY DOCS is very severe relative to comparable settings in other states, especially because isolated confinement can stretch into an unlimited time period. (And even in states where routines are less severe, prisoners with serious mental illness are excluded from isolated confinement.) Prisoners are in their cells nearly 24 hours per day, they are not permitted any kind of congregate activities, and they will remain in this type of very restricted and isolated confinement until their SHU term is over or their release date arrives. In contrast, many states are alleviating the extreme isolation and idleness of isolated confinement by incrementally providing prisoners in isolation units with progressively more out-of-cell activities, group events and programming. Wisconsin, New Mexico and Connecticut Departments of Corrections have designed phase programs that permit prisoners in isolated confinement to earn incrementally more social interaction and more meaningful programming. In Florida, with the settlement of Osterback v. Moore,[111] the Department of Corrections established for prisoners in Closed Custody (isolated confinement) phased release from their cells for progressively more hours each day so they could take part in a wide variety of mental health treatment modalities, including group therapy, anger management, substance abuse treatment, psycho-education and so forth. This is in stark contrast to the situation in NY DOCS, where prisoners in SHU spend all of their time alone in a cell and their mental health treatment is limited to medications and mostly cell-front contact with

[110] Multiple OMH staff members testified that SHU is designed to be a punitive setting. (see Key deposition, p. 187; Devito deposition, pp. 162-163.)

[111] US DIST CT SO DIST FLORIDA, MIAMI DIVISION, CASE NO. 97-2806-CIV, 2001.

OMH staff. Even with the SHU Plan of Improvements (which provide access to two private sessions with a therapist per month and one private session with a psychiatrist), prisoners in SHU spend virtually all of their time alone in a cell. (See Miraglia deposition, p. 125-126).

In terms of suicide prevention, crisis intervention and the use of observation cells, New York DOCS' very punitive approach to suicidal prisoners is much more harsh than the evolving standards in the field require (Hayes, NCCHC). In Connecticut, there is a strict limit to the time a prisoner can be held in observation at Northern Correctional Institution, an isolated confinement facility, the idea being to either resolve the crisis quickly or transfer the individual whose crisis cannot be resolved quickly enough to the acute psychiatric hospital unit, where more intensive mental health treatment is available. The National Commission on Correctional Health Care (NCCHC) standards on seclusion and restraint include these provisions: "b. In each case, use is authorized by a physician or other qualified health care professional where permitted by law, after reaching the conclusion that no other less restrictive treatment is appropriate,... d. The treatment plan provides for removing patients from restraints or seclusion as soon as possible,... 'When clinically ordered restraint or seclusion is used, it is employed for the shortest time possible in keeping with current community practice.'"[112] The long stays in observation cells in OMH Satellite Mental Health Units, under very harsh and restrictive conditions, are well beneath the evolving standards and practices in the correctional mental health field.

Thus, in these ways, NY DOCS falls behind evolving national standards and practices.

VIII. The Problems are Longstanding and Well-Known by Defendants

DOCS and OMH are very aware of all of the problems I have raised in this report. Since this litigation was initiated, OMH and DOCS have been making limited efforts to correct some of the deficiencies and unacceptable practices that I have identified. For example, as an effort to ameliorate the problem of lack of confidentiality in cell-front mental health interviews in isolated confinement units, Dr. Don Sawyer notified OMH staff that all prisoners in SHU who are on the OMH caseload must be provided a private interview with OMH staff at least twice per month and access to a psychiatrist once per month.[113] This is definitely an improvement over exclusive cell-front interviews. However, cell-front interviews continue to be the main form of contact between OMH staff and prisoners for the purpose of 90 day mental health assessments in SHU, for OMH contact with prisoners in Keeplock and prisoners in observation. And even the private

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[112] National Commission on Correctional Health Care, Correctional Mental Health Care: Standards & Guidelines for Delivering Services, Chicago: NCCHC, 2003, pp. 143-144.

[113] Memo of 6/25/03, Sawyer to Unit Chiefs; see also SHU Plan of Improvement, 4/15/05, which incorporates this requirement.

interviews that have been added to the OMH interventions in SHU do not seem to last very long, do not occur frequently enough, and do not necessarily involve the kind of trusting therapeutic interviews that are urgently needed to effectively treat prisoners with serious mental illness. Thus the changed policy does not go nearly far enough in the direction of solving the problem I pointed out regarding confidentiality.

There are other new developments that have been initiated since this litigation was initiated, including: prisoners who suffer from SMI and have been designated mental health service level one will remain on the OMH caseload for the remainder of their term.[114] Pursuant to a prior decree in the Anderson litigation, Case Management Committees have been instituted in an effort to provide more comprehensive mental health care and better staff collaboration; more effort is to be made to acquire past clinical records for prisoners admitted to the OMH caseload at Downstate's Reception Unit[115]; new rules have been formulated for OMH participation in the disciplinary process since the Anderson settlement; more ICP beds are being requested in budget proposals; a Behavioral Health Unit is proposed; and studies have been conducted of various components of OMH mental health services. All of these changes are steps in the right direction, with the exception of proposals for the Behavioral Health Units, which, if effected in accordance with the materials provided for my review, I am afraid, are likely to replicate the very problems they were designed to ameliorate.[116] But it will be a long time before many of these changes could actually improve services to the current population of prisoners with serious mental illness, if they ever do. And most of the problems I have identified reflect ingrained staff attitudes – for example, a punitive approach to suicidal prisoners and insensitivity to their complaints of emotional distress – and change of staff attitudes will require robust training and a kind of leadership that OMH and DOCS have not heretofore been able to demonstrate. And considering the fact that DOCS and OMH have known for a long time about the longstanding problems I have delineated, and have known about the great harm done to prisoners with serious mental illness, recent efforts on the part of OMH and DOCS to ameliorate the problems have not gone nearly far enough.

Thus, OMH and DOCS are very aware of the high incidence of serious mental illness in the DOCS population, and the fact that the proportion of prisoners with serious mental illness has been rising even as the population has grown dramatically.[117]

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[114] See Sawyer deposition, pp. 216-217; and Memo from Donald Sawyer to Unit Chiefs, 10/16/02.

[115] OP P&P manual on Internet, Sec. II, p. 9.

[116] See my comments about Proposals for Behavioral Health Units in Section VII.I.3. I make all of these comments regarding the BHUs as a tentative opinion only, since I understand that I am to have the benefit of further discovery once the BHUs are up and running.

[117] Hal Smith, Donald A. Sawyer, and Bruce B. Way, "Central New York Psychiatric Center: An Approach to the Treatment of Co-Occurring Disorders in the New York State Correctional Mental Health System,"

OMH and DOCS have been aware that prisoners are transferred to maximum security prisons solely because they are in need of more intensive mental health treatment.[118]

OMH and DOCS are well aware that mental health treatment programs have not grown apace with the number of prisoners suffering from mental illness in DOCS, and that there are serious deficiencies in staffing, psychiatric services, the number of inpatient beds, the number of slots in ICP and other mental health programs, and the treatment and housing available for prisoners who are both disruptive and suffer from serious mental illness.[119] According to Dr. Don Sawyer, even though the number of inmates in DOCS receiving outpatient mental health services increased by approximately 5,000 outpatients from 1996 to 2000, and expansion of the number of inpatient beds was needed, CNYPC was unable to obtain additional inpatient beds.[120] Dr. Bruce Way's studies reflect a need for many additional ICP beds.[121]

OMH and DOCS are also well aware (and have been for over a decade, if not longer) that prisoners' mental illness drives many of the behaviors that land prisoners with serious mental illness in isolated confinement.[122]

OMH and DOCS are well aware that prisoners with serious mental illness are vastly overrepresented in isolated confinement.[123]

Behavioral Sciences and the Law, 20: 523–534, 2002; CNYPC Governing Body discussion of increased acuity of mental illness, Pl. Ex. 461, p. 4); numerous communications among OMH administrators about increasing OMH caseload, see 1/11/05 testimony of Richard Miraglia (Miraglia Tr. 185:8-186:7) or 1/23/04 email Beane to Van Heusen, OMHCNY 087962-087963.

[118] 1999 Memorandum of Understanding Between OMH and DOCS, p. 2.

[119] Smith, H. E., NYS OMH Task Force on the Future of Forensic Services: Report of the Subcommittee on Prison Mental Health Services, NY: 1/31/97. That report noted: "New York has lower per capita inpatient beds than all other states of comparable or smaller (inmate) populations with the exception of New Jersey.... And.... The outpatient program is becoming less and less able to provide ongoing monitoring and supportive therapy for an increasingly mentally disabled population," cited in the June, 2004, Correctional Association of New York publication, "Mental Health in the House of Corrections: A Study of Mental Health Care in New York State Prisons," p. 11.

[120] 5/31/00 Great Meadow Satellite Unit Meeting Minutes, OMHGM 0010380.

[121] 10/3/03 "Estimates Regarding ICP Bed Expansion," OMHCNY 090163.

[122] Deposition transcripts of Selsky, p. 161-162, Lord, 26:4-15, 30:5-14; Shimkunas, 122:8-12, DeVito 138:12-20, Miraglia 120 – 121; and the 2002 OMH SHU Study.

[123] 2002 OMH SHU Study and the 2004 OMH SHU Study, see also Way Deposition, pp. 546-547, and Dr. DeVito's statement in his deposition that some prisoners with mental illness are in SHU for 10 years or more, p. 153.

OMH and DOCS are very aware that a very disproportionate number of suicides within DOCS occur in isolated confinement, and in many cases serious risk of suicide goes undetected, as reflected in Dr. Way's studies of suicide and in many reports regarding suicides by the State Commission of Corrections.

OMH and DOCS have long been aware that isolated confinement causes psychiatric damage to prisoners, especially prisoners already known to suffer from serious mental illness.[124] Hal Smith, Executive Director of CNYPC, wrote to Richard Miraglia on 10/14/99 that "it has been demonstrated that high risk of suicide and serious psychiatric decompensation are primary factors in managing SHU populations" (Pl. Ex. 485). And a 9/25/2000 written communication from the NY State Commission of Correction to DOCS and OMH officials states it "is a well established fact that inmates serving long term sentences in SHUs are likely to decompensate due to extended periods of isolation and sensory deprivation." (Pl Ex. 95). And a NY State Commission on Quality of Care in 2003 found that in SHUs, "decompensation, self-harm, suicide are all issues that need to be addressed."[125]

OMH and DOCS are well aware that prisoners spend an unacceptably long time in observation cells even though OMH believes prisoners should not spend more than three days there,[126] that conditions in these cells are very barren and induce a "loss of dignity,"[127] that observation cells as currently utilized do not constitute adequate mental health treatment for prisoners in crisis.[128]

OMH and DOCS are well aware that prisoners suffering from serious mental illness should be transferred to appropriate treatment programs and not left in isolated confinement.[129]

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[124] In their depositions, Dr. Sawyer, Dr. Shimkunas, and Dr. DeVito all acknowledge that isolated confinement causes distress and deterioration in prisoners suffering from serious mental illness. Dr. Don Sawyer, when asked in his deposition "Do you agree that special housing units may cause a patient to get anxious, helpless, hopeless and need a higher level of care?," responded "Yes, that setting as well" (pp. 476-477). And Miraglia, in his deposition, states that some prisoners with mental illness cannot withstand the stress of disciplinary housing (p. 31).

[125] 12/4/03 email, Sawyer to Smith and Way, OMHCNY 091628-091629).

[126] Elaine Lord testified that prisoners spend as long as several months in observation, deposition, p. 152; Pl. Ex. 347; Sawyer deposition pp. 101-102.

[127] Findings of the NY State Commission on Quality of Care for the Mentally Disabled, 2003, OMHCNY 087407.

[128] 12/4/03 email, Sawyer to Smith and Way.

[129] Elaine Lord deposition, pp. 115-117; Loretta Klein deposition, pp. 184-185.

OMH and DOCS are well aware of the tendency on the part of OMH staff to dismiss prisoners' emotional complaints because of excessive concern that they might be manipulating or malingering or might suffer only from an "Axis II" diagnosis.[130]

A stipulation entered in the Eng litigation (ordered in 1998, then amended and ordered in 2000) required that prisoners with severe mental disorders or severe depression were not to be housed in the Attica SHU if they were exhibiting symptoms requiring immediate treatment or evaluation in a mental health setting or were known to be at substantial risk of serious psychiatric deterioration. I discovered, however, that prisoners that fit this criteria continued to be housed in the Attica SHU.

Thus, even though it is well known by high-ranking officials and clinicians in OMH and DOCS that the number of prisoners with serious mental illness is growing rapidly, that mental health services have not grown apace and do not serve the needs of these prisoners, that inadequately treated prisoners with serious mental illness are likely to behave in such a way as to get tickets and be sent to isolated confinement, that isolated confinement causes their psychiatric condition to deteriorate and/or leads to suicide in too many cases, that a vastly disproportionate number of the suicides that have occurred in DOCS involve prisoners assigned to isolated confinement, that prisoners with serious mental illness are prone to lengthy terms in isolated confinement, that many prisoners with serious mental illness repeatedly cycle from isolated confinement to observation or CNYPC and then back to isolated confinement as their psychiatric condition and prognosis become worse. Given all of this, one wonders why OMH and DOCS do not correct the deficiencies in mental health care within DOCS and why they continue to actually utilize isolated confinement as a method for managing prisoners with serious mental illness.

IX. Recommendations

1. Mental Health Services in general. Comprehensive mental health services must be provided to all prisoners in need. Adequate mental health treatment requires the availability of a trained clinician to develop a trusting relationship with a patient in a setting that permits privacy, where confidentiality is respected so that very personal themes can be explored and worked through. Adequate mental health treatment requires a variety of treatment modalities, including but not limited to crisis intervention; psychotropic medications as needed; the availability of a certain number of group activities such as group therapy, psycho-educational groups, facilitated socialization or recreational activities, and psychiatric rehabilitation groups that involve psycho-educational programs, training in the skills of daily living and medication compliance; admission to an acute psychiatric hospital as needed; social work outreach to family members as needed; and after-care planning so that the disturbed individual is not

[130] Dr. Angela Browne report of 8/26/-27/02 site visit at Bedford Hills, Pl Ex. 111; and Dr. Stuart Grassian's 1999 report about the Attica SHU for the Eng litigation (Eng v. Gord, Civ. 80-3855, p. 2).

returned to the environment that caused a breakdown but rather is provided with the ongoing care and social supports needed to sustain his mental health. Not all of these modalities need to be available in any particular setting, and not all of them need to be utilized with any particular prisoner. But they need to be available and accessible.

There should be more programs and out-of-cell activities for prisoners with serious mental illness, wherever they are housed. And there should be more congregate activities, sufficiently supervised to insure safety. In housing units such as ICP and STP, where the purpose is mental health treatment, all of the out-of-cell activities that comprise an effective acute psychiatric treatment program must be instituted, including milieu meetings, group and individual therapy in a private and confidential setting, psychiatric rehabilitation programs and so forth. Sufficient number of qualified staff must be made available to conduct this programming, as to render effective treatment.

Prisoners with SMI should not be ejected from treatment programs on disciplinary grounds.

There should be no double-celling for prisoners with SMI in any location.

2. Exclusion from Isolated Confinement of Prisoners with SMI. Policies and practices need to be changed to exclude prisoners with serious mental illness from isolated confinement of all types. No prisoners with a history of serious mental illness, no prisoner with serious mental illness who is currently symptomatic, and no prisoner currently being treated for a serious mental illness should be in isolated confinement (SHU, Keeplock, Administrative Segregation and Protective Custody when protection involves isolation[131]).

Implementation of this recommendation requires thorough mental health assessment upon admissions to DOCS, prior to transfer to isolated confinement, and periodically thereafter once the prisoner arrives in isolated confinement. An effective ongoing 90 day mental health evaluation should be conducted in a confidential setting, and should be of a duration that permits adequate assessment as well as exploration of possible toxic effects of isolated confinement.

The practice of time-cuts and suspension of SHU terms for mental health reasons must be expanded and made more meaningful.

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[131] In a correctional setting, protective custody is designed to provide safety for a vulnerable prisoner. It is not a punitive designation. Therefore, prisoners in protective custody should have available all privileges and programs that are available to others in their classification. There is no penological objective served by placing them in isolated confinement. They require protection, not isolation and idleness. Yet many prisoners who are assigned protective custody status within DOCS spend their time in isolated confinement. Prisoners with SMI very often require protection. This is why I include this designation in my statements about isolated confinement and its effects on prisoners with SMI.

3. CNYPC. The number of beds available for DOCS patients at CNYPC needs to be increased significantly. Another option is to utilize other psychiatric hospitals in the community for inpatient treatment of DOCS prisoners on a contractual basis – this option would help solve the transportation problem when only one inpatient facility in the state serves all the prisons.

The criteria for admission to CNYPC should be changed so that prisoners who do not meet criteria for civil commitment but require psychiatric hospitalization can be admitted.

CNYPC Discharge recommendations, such as "transfer to ICP," must be carried out. A lack of bed-space at CNYPC and a lack of bed-space in the recommended program should not be a reason for sending the prisoner to a less intensive mental health treatment program than is clinically indicated. For example, if a prisoner is ready to be discharged from CNYPC but the OMH clinicians recommend that prisoner be transferred to an ICP and there is no available bed in an ICP, the prisoner should not be transferred to a general population or SHU unit where the level of mental health care is below what is available in ICP. Rather, the patient should be retained at CNYPC until a bed in the appropriate treatment program opens up. Of course, other recommendations I make will result in more beds being available in ICP and other treatment programs as well as more beds at CNYPC, so this problem will not be as acute.

4. Crisis Intervention. Regarding suicide prevention and treatment, detection and prevention need to begin with prisoners' admission to DOCS. Thus, early warning signs need to be heeded, and past psychiatry history of self-harm needs to be taken as a serious predictor of future crises. By beginning early to think about which prisoners are likely to pose a risk of suicide in the future, DOCS AND OMH staff can work to alleviate some of the stresses that would make suicide more likely. For example, with a male prisoner who has attempted suicide in the past when he felt in danger in a prison, staff can make efforts to make certain he feels safe and therefore does not need to resort to self-destructive behaviors.

The program in the Mental Health Satellite Units should be upgraded and made non-punitive. A significant amount of intensive, confidential, face-to-face contact with a mental health worker/psychotherapist must be offered, the conditions of confinement in observation cells should be improved so that observation is not punitive, mental health staff should have much more input into decisions about searching entering prisoners and the amenities they will be permitted, prisoners who qualify on a security basis must be provided greater amenities and comforts while going through a suicidal crisis, and if a prisoner is in observation for longer than 24 hours (or 48 hours over a weekend), then he or she must be transferred to CNYPC where more thorough assessment and more intensive mental health services can be provided. In general, prisoners in the crisis unit (observation and dormitories) should receive the quality of treatment and should have the rights and protections that are well-recognized in mental health treatment settings in the

community – e.g., seclusion and restraint must be utilized for the shortest time possible, all less restrictive interventions must have been tried prior to consignment of the patient to seclusion or restraint, there must be frequent monitoring by health and mental health staff (federal standards require hourly monitoring plus frequent re-examinations by a physician who re-writes orders for seclusion and restraint after seeing the patient).

The dormitories in the Satellite Mental Health Units should be utilized fully, thus alleviating some of the problem of bed shortage in mental health treatment programs. Either more of the prisoners who are treated in the Satellite Mental Health Units need to be designated suitable for dormitory dwelling, or the dormitories need to be split into private rooms where patients can be housed.

Suicide risk assessment must be upgraded and standardized. Screening suicide risk assessment should be administered in Reception to all prisoners, and should be administered again to those who are being transferred to isolated confinement and periodically thereafter. A more rigorous version should be administered upon report of suspected risk by security staff and upon admission to observation or CNYPC. The OMH Form 336 ADM (MH) 7/01, "Suggested Guide for Risk Assessment for Suicide in Jails," can be adapted to the prison setting and used as a model for the type of information that should be carefully gathered and recorded in the course of suicide risk assessment, but the form should be filled out by a qualified clinician who personally examines the prisoner.

Confinement in an observation cell should not include deprivation of recreation and out-of-cell activities. In fact, to the extent possible, out-of-cell programming and activities should be encouraged and supported.

Admissions to observation should be tracked and reviewed, both as a measure to identify prisoners at risk and as a quality assurance mechanism. Any prisoner who is admitted to observation or CNYPC on multiple occasions should be suspected of suffering from a more serious mental illness than was previously assumed, and should be examined more intensively. CNYPC is already studying admissions to observation, and this kind of study is encouraged.

5. Intermediate Care Program (ICP) and Special Needs Unit (SNU). The number of beds in ICP should be greatly expanded, and by a much larger number of beds than is reflected in the CNYPC 2004-2005 plan (which states that 87 ICP beds will be added to the 565 that now exist). The programming should be enriched, as is indicated in the CNYPC plan for ICP.

The number of beds in the SNU program for prisoners with Developmental Disabilities and Mental Retardation needs to be greatly expanded. A rigorous study of the needs of prisoners with co-occurring serious mental illness and Developmental Disabilities/ Mental Retardation should inform this expansion, and the expansion of SNU capacity should be adequate to provide safety and treatment to all those who need it.

Prisoners should not be discharged from ICP for disciplinary reasons; rather a system for managing behavior problems including rule-violation and assaultiveness should be established within the ICP.

6. Special Treatment Program (STP) and Behavioral Health Unit (BHU). STP inmates should not be housed in the SHU, the time period needs to be specified and needs to be relatively short, the STP program needs to have the explicit aim of moving prisoners with SMI out of isolated confinement, more out-of-cell activities are needed, therapeutic activities need to occupy much more of the day than the current two hours of programming that includes treatment and education, there needs to be a halt to keeping STP inmates housed in the SHU after completion of the STP, and confidentiality needs to be enforced (i.e. no officers in group sessions). Use of "cages" in the group rooms within the STPs should be discontinued, and a more humane method for maintaining security should be established. Smaller groups would lessen the security threat of group treatment in the STPs, and there are other security measures that can be adopted.

Proposals for BHUs need to be re-designed so that the program is therapeutic rather than punitive, so that there is no harsh entry phase where prisoners with SMI are likely to get stuck and fail to advance to other phases of the program, so that the disciplinary process stays within the BHU program and does not cycle prisoners to DOCS and isolated confinement, and so that there is more intensive mental health treatment available.

7. Re: Medium Security Mental Health Programs. Mental health services at medium security facilities and other levels of security need to be upgraded so that prisoners in need of more intensive mental health treatment will not as readily be transferred to maximum security facilities where conditions are more harsh and repercussions of disciplinary tickets more severe.

8. Re: Substance Abuse Treatment. Since "Dual Diagnosis" or co-occurring substance abuse and mental illness, are very prevalent in the DOCS population, and since substance abuse is an Axis I diagnosis in itself, every prisoner should have a history of substance abuse and substance abuse treatment in the clinical chart. All prisoners in need of substance abuse treatment should have access to comprehensive substance abuse treatment, regardless of housing assignment. This means that even prisoners in isolated confinement should have access to ongoing substance abuse treatment. Substance abuse treatment needs to be administered by adequately trained and certified professional staff. Substance abuse treatment needs to be provided in isolated confinement settings. Cell-study manuals are not an acceptable fulfillment of this requirement, since many of the prisoners are not literate enough to succeed at cell-study, and the conditions of isolation and idleness interfere with the capacity of many literate prisoners to concentrate and complete assignments. Leaderless 12-step programs such as Alcoholics Anonymous can be part of the comprehensive treatment program, but should not be a substitute for substance abuse treatment administered by qualified professional staff.

9. Rehabilitation and Education Programs. Vocational, Educational and other general rehabilitation programs need to be upgraded and maintained so that prisoners with SMI will have appropriate health-supporting activities and programs available to them as they engage in mental health treatment. Social interaction is a critical component of mental health treatment, and the availability of general rehabilitation and educational programs in a correctional setting is the best way to provide the types of constructive social interactions that individuals suffering from serious mental illness need.

10. Record Keeping. Clinical charts must be upgraded significantly. Treatment plans and rationales for all interventions should be clearly stated in the clinical chart. Past psychiatric history, including records from previous psychiatric treatment within DOCS, in jail, and in the community, should be indicated in the chart. Past records should be requested and entered in the chart. Medical history and significant medical intervention, including non-psychiatric medications being prescribed, should be reflected in the mental health chart. History of past traumas should be reflected in the chart. Psychiatric medications and dosages should be clearly listed in the Progress Notes, and all prescribing and changes of medications should be noted and a clear rationale for same be inserted in the chart. Clinicians who examine prisoners on an emergency or elective basis should have access to the clinical chart, including past history and treatment regimens, and should rely on same in doing their assessment. There should be more consistency in the clinical record, for example when a prisoner is discharged from a program such as CNYPC or observation, and recommendations are made as to follow-up treatment, there should be tracking to see if the recommended follow-up treatment has occurred. DOCS and OMH should collaborate on record-keeping, within the constraints of confidentiality. Confidential clinical information should not be available to DOCS staff, but when a prisoner is discharged from a treatment program and re-admitted to a housing unit, and when disciplinary sanctions are determined, both DOCS and OMH should be informed of the movement and the sanctions.

11. Mental Health Screening and the diagnostic process. There needs to be thorough revision and upgrading of the process of diagnosis regarding mental illness, suicide risk, developmental disabilities and mental retardation, neurological conditions such as closed head injuries, and substance abuse. More thorough screening and assessment is needed at every stage of the prisoner's progression through the system. In Reception, all entering prisoners should be examined by qualified OMH staff, including face-to-face interviews and mental status examinations (currently approximately 40% of prisoners in Reception are seen by OMH face-to-face). All prisoners must be thoroughly assessed in Reception for mental illness, suicide potential, Developmental Disabilities, Mental Retardation, Neurological illness and substance abuse. Psychological assessments should not rely on a few test instruments to rule out SMI; rather a comprehensive review of records, history, mental status and more complete testing should be performed and taken into consideration in arriving at appropriate diagnoses and treatment plans. The Hare Psychopathy Checklist should not be relied upon to rule out SMI, rather it can play a

part in diagnosing co-occurring personality disorder and in informing appropriate treatment options.[132] Periodic and strategic thorough mental health assessments should be carried out with all prisoners prior to transfer to isolated confinement and at 90 day intervals once prisoners are in isolated confinement. Appropriate Neuropsychological Assessment and Neurological examination should be readily available and utilized as clinically indicated. The fact that a prisoner is deemed to be "manipulative," "malingering," or to have "no Axis I diagnosis" at one point in time should not bias subsequent examinations and services – i.e. staff should be aware that individuals can be both manipulative and suffer from SMI, and individuals can exhibit signs of mental illness at one point in time and not at another. Adequate diagnosis requires that the entire clinical picture be considered, including patterns of exacerbations and remissions.

12. Behavior Management Plans. Behavior Management Plans should not be viewed as an alternative to mental health treatment plans, rather they can help delineate a treatment strategy. In other words, if a particular personality disorder is known to reduce the gain from one kind of psychotherapeutic intervention, but another kind of intervention is known to work with this group of patients, then that distinction can be delineated in a Behavior Management Plan. For example, for prisoners with Antisocial Personality Disorder that is co-occurring with SMI, a Behavior Management Plan can indicated that a particular form of psychodynamic intervention is not likely to be effective while Behavior Therapy, Cognitive-Behavior Therapy (CBT) or Dialectical Behavior Therapy (DBT) is indicated for this patient. This kind of plan to administer the most effective treatment modality in no way means that adequate treatment targeting the co-occurring SMI can be left out of the plan. And there should be no foreclosure of future contact with mental health providers, nor of admission to a more intensive mental health treatment unit.

13. Removal from OMH Caseload. Prisoners who have been admitted to CNYPC or observation, and those known to suffer from serious mental illness, should not be removed from the OMH caseload, even if they are non-compliant with treatment. If they are in remission and do not desire services, they should be monitored at regular intervals so that any emerging problems and disability can be detected and, within the context of a therapeutic relationship, they can be offered services that staff feel are indicated. Non-compliance with treatment should not be a reason for discharging patients with SMI from the OMH caseload. Rather, the non-complying patient must be offered appointments at regular intervals, re-assessed by a psychologist and psychiatrist, offered psycho-education about the illness and treatment, and if the prisoner is merely refusing to take medications he or she should be offered appropriate non-medication forms of treatment. The recent OMH Outpatient Plan of Improvement mandates that prisoners

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[132] As discussed in Section VII.I.2, recent clinical research contradicts the notion that individuals who score high on the Psychopathy Checklist cannot benefit from psychotherapy and other mental health treatments – in fact, for some in this sub-population, psychotherapy is one of the best ways for staff to reach them, stabilize their co-occurring Axis I disorder, and foster positive change.

who have been on Mental Health Level 1 not be removed from the OMH caseload. This is a positive change, but prisoners who are known to be suffering from serious mental illness, prisoners who have required emergency admission to observation or CNYPC, and prisoners who have exhibited self-harm and suicidal behaviors should also not be removed from the OMH caseload while in DOCS.

14. Discipline. There should be no punishment for behaviors that are clearly driven by psychiatric illness, for example, actions taken by prisoners at the behest of command hallucinations, or self-destructive acts (whether they be suicidal in intent or serve some other emotional purpose such as the relief of anxiety) on the part of depressed and suicidal prisoners.

While the settlement agreement in Anderson is being implemented, there needs to be monitoring to see how effectively mental health staff intervene and collaborate in the disciplinary process. Collaboration between OMH staff, officers writing tickets, and hearing officers needs to be greatly improved.

15. Use of Force. All incidents of use of force involving prisoners with SMI should be reviewed by OMH staff as soon as possible. Where possible, OMH staff should be contacted prior to planned use of force and should intervene to see if they can help the prisoner change his or her behavior so that use of force will not be necessary.

16. Monitoring of Disciplinary Procedures as an Aide to Screening for SMI. When a prisoner who is not on the OMH caseload, or has not been determined to suffer from a serious mental illness, spends an inordinately long time in isolated confinement, accumulating ever more tickets after being transferred into isolated confinement, this should be interpreted as a possible red flag indicating that psychiatric breakdown is occurring. Similarly, if a prisoner in a phase program (at Southport or Upstate or the proposed BHU), fails to pass through the lower phases of a program or returns to the lower phases after failing to pass a higher phase, then this should be interpreted as presumptive evidence of previously undetected or worsening SMI until proven otherwise, and a thorough mental health assessment should be initiated.

17. Medications. There should be adequate psychiatric examinations and medication monitoring, including appropriate laboratory tests. The psychiatrist must actually examine in a confidential setting the prisoners for whom he or she prescribes, and their meetings should provide an opportunity for substantial discussion about the prisoner's condition and the treatment, including possible side effects of medications and alternative treatments that are available. The psychiatrist must not prescribe via proxy. There should be appropriate notations in chart, including treatment plans explaining rationale for medication prescribing and changes in medication regimens. Appropriate laboratory work should be done, including follow-up interventions when blood tests such as Lithium or Depacote levels are abnormal or do not attain a therapeutic range. Patients who suffer from SMI and present extreme behavior problems should be given a trial of the anti-psychotic agent, Clozaril, as indicated. Medication over Objection should take

place only in a mental health treatment setting. Rivers orders are currently permitted to "travel" to facilities with Satellite Mental Health Units; but in those facilities, prisoners requiring "traveling Rivers orders" must be confined in either the Dormitory unit or the ICP.

18. Confidentiality. Cell-front interviews should be understood for what they are: brief contacts that serve merely to check on the status of prisoners and arrange a private, confidential meeting. Cell-front meetings are no substitute for private, confidential meetings. All substantial talk about psychiatric symptoms, suicide ideation, medications and so forth should occur in a confidential setting. In spite of the attention to this issue in the SHU Plan of Improvement, there is a continuing problem of cell-front, non-confidential meetings with OMH staff and the meetings between OMH staff and prisoners in isolated confinement that are occurring in private, confidential settings seem to be quite brief. There needs to be more attention to this problem. Security staff must not be privy to confidential mental health information, and must not be permitted to be in areas (such as the group room in STP) when confidential discussions are occurring.

19. Post-release Planning. Post-release planning needs to be upgraded and expanded. Prisoners must not be precluded from post-release planning on account of their housing assignment or disciplinary status. Prisoners who are, or have been on the OMH caseload should be removed from isolated confinement at least six months prior to being released from their prison term, and should participate in an intensive program designed to prepare them for return to the community.

20. Staff training. Much more training is needed for non-mental health staff about mental illness and suicide, and about relating to prisoners with mental illness. Mental health staff need more training about gender and cultural issues, personality disorders and treatment for individuals who have experienced trauma. Sensitivity regarding gender, race, culture and disabilities needs to be enhanced through rigorous training. Moreover, training about security for mental health staff needs to be upgraded. In other words, "cross-training" should be expanded, and topics such as cultural competence, stigma towards people suffering from serious mental illness, childhood trauma, gender relations and so forth should be included in the enhanced training for both mental health staff and security staff. All staff need to be trained in order to increase sensitivity toward prisoners with mental illness, to resist the temptation to dismiss the symptoms of patients who are difficult, who are perceived as manipulative, or who have a personality disorder – after all, many prisoners suffering from serious mental illness are difficult in one way or another.

21. Staff collaboration. More collaboration is needed between mental health and security staff, so that mental health staff does not simply accept security staff's decisions about discipline, housing, etc., but rather discusses and resolves these issues in collaborative fashion. In this collaborative process, significant weight needs to be given to the prisoner's mental health needs so that the resolution is not simply punitive.

Respectfully submitted,

Terry A. Kupers

Terry A. Kupers, M.D., M.S.P.

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APPENDIX A

CURRICULUM VITAE

Terry Allen Kupers, M.D., M.S.P.

Office Address:
#8 Wildwood Avenue, Oakland, California 94610
Phone Number: 510-654-8333

Currently:
Professor, Graduate School of Psychology, The Wright Institute,
2728 Durant Avenue, Berkeley, California 94704
Private Practice of Psychiatry, Oakland
Consultant: Progress Foundation, San Francisco

Family: Married to Arlene Shmaeff, Education Director at the Museum of Children's Art (M.O.C.H.A.) in Oakland; father of three young adult sons

Born: October 14, 1943, Philadelphia, Pennsylvania

Education:
B.A., With Distinction, Psychology Major, Stanford University, 1964
M.D., U.C.L.A. School of Medicine, 1968
M.S.P. (Masters in Social Psychiatry), U.C.L.A., 1974

Training:
Intern (Mixed Medicine/ Pediatrics/ Surgery), Kings County Hospital/Downstate Medical Center, Brooklyn, New York, 1968-1969.
Resident in Psychiatry, U.C.L.A. Neuropsychiatric Institute, Los Angeles, 1969-1972
Registrar in Psychiatry, Tavistock Institute, London (Elective Year of U.C.L.A. Residency) 1971-1972
Fellow in Social and Community Psychiatry, U.C.L.A. Neuropsychiatric Institute, 1972-1974

License: California, Physicians & Surgeons, #A23440, 1968-Present

Certification: American Board of Psychiatry and Neurology (Psychiatry, #13387), 1974-Present

Honors:
Alpha Omega Alpha, U.C.L.A. School of Medicine, 1968
Distinguished Fellow, American Psychiatric Association; Fellow, American Orthopsychiatric Association
Listed: *Who's Who Among Human Services Professionals (1995-); Who's Who in California (1995-); Who's Who in The United States (1997-); Who's Who in America (1998-); International Who's Who in Medicine (1995-); Who's Who in Medicine and Healthcare (1997-); The National Registry of Who's Who (2000-); Strathmore's*

Millenial Edition, Who's Who; American Biographical Institute's International Directory of Distinguished Leadership; Marquis' Who's Who in the World (2004-)

Helen Margulies Mehr Award, Division of Public Interest (VII), California Psychological Association, Affiliate of American Psychological Association, March 30, 2001

Stephen Donaldson Award, Stop Prisoner Rape, 2002

2005 Exemplary Psychiatrist Award, National Alliance for the Mentally Ill

Clinical Practice:

Los Angeles County, SouthEast Mental Health Center, Staff Psychiatrist, 1972-1974

Martin Luther King, Jr. Hospital, Department of Psychiatry, Los Angeles Staff Psychiatrist and Co-Director, Outpatient Department, 1974-1977

Contra Costa County, Richmond Community Mental Health Center, Staff Psychiatrist and Co-Director, Partial Hospital, 1977-1981

Private Practice of Psychiatry, Los Angeles and Oakland, 1972 to present

Teaching:

Assistant Professor, Department of Psychiatry and Human Behavior, Charles Drew Postgraduate Medical School, Los Angeles, and Assistant Director, Psychiatry Residency Education, 1974-1977

Professor, Graduate School of Psychology, The Wright Institute, Berkeley, 1981 to present

Courses Taught at: U.C.L.A. Social Science Extension, California School of Professional Psychology (Los Angeles), Goddard Graduate School (Los Angeles), Antioch-West (Los Angeles), New College Graduate School of Psychology (San Francisco).

Professional Organizations:

American Psychiatric Association (Distinguished Fellow); Northern California Psychiatric Society; East Bay Psychiatric Association (President, 1998-1999); American Orthopsychiatric Association (Fellow); American Association of Community Psychiatrists; Physicians for Social Responsibility; National Organization for Men Against Sexism; American Academy of Psychiatry and the Law; International Association of Forensic Psychotherapy

Committees and Offices:

Task Force on the Study of Violence, Southern California Psychiatric Society, 1974-1975

Task Force on Psychosurgery, American Orthopsychiatric Association, 1975-1976

California Department of Health Task Force to write "Health Standards for Local Detention Facilities," 1976-77

Prison/ Forensic Committee, Northern California Psychiatric Society, 1976-1981; 1994-Present

Psychiatry Credentials Committee, Alta Bates Medical Center, Berkeley, 1989-1994 (Chair, Subcommittee to Credential Licensed Clinical Social Workers)

President, East Bay Chapter of Northern California Psychiatric Society, 1998-1999

Co-Chair, Committee on Persons with Mental Illness Behind Bars of the American Association of Community Psychiatrists, 1998-2003

Consultant/Staff Trainer:

Contra Costa County Mental Health Services; Contra Costa County Merrithew Memorial Hospital Nursing Service; Bay Area Community Services, Oakland; Progress Foundation, San Francisco; Operation Concern, San Francisco; Marin County Mental Health Services; Berkeley Psychotherapy Institute; Berkeley Mental Health Clinic; Oregon Department of Mental Health; Kaiser Permanente Departments of Psychiatry in Oakland, San Rafael, Martinez and Walnut Creek; Human Rights Watch, San Francisco Connections collaboration (Jail Psychiatric Services, Court Pre-Trial Diversion, CJCJ and Progress Foundation)

Forensic Psychiatry (partial list):

Testimony in Madrigal v. Quilligan, U.S. District Court, Los Angeles, regarding informed consent for surgical sterilization, 1977

Testimony in Rutherford v. Pitchess, Los Angeles Superior Court, regarding conditions and mental health services in Los Angeles County Jail, 1977

Testimony in Hudler v. Duffy, San Diego County Superior Court, regarding conditions and mental health services in San Diego County Jail, 1979

Testimony in Branson v. Winter, Santa Clara County Superior Court, regarding conditions and mental health services in Santa Clara County Jail, 1981

Testimony in Youngblood v. Gates, Los Angeles Superior Court, regarding conditions and mental health services in Los Angeles Police Department Jail, 1982

Testimony in Miller v. Howenstein, Marin County Superior Court, regarding conditions and mental health services in Marin County Jail, 1982

Testimony in Fischer v. Geary, Santa Clara County Superior Court, regarding conditions and mental health services in Santa Clara County Women's Detention Facility, 1982

Testimony in Wilson v. Deukmejian, Marin County Sup Court, regarding conditions and mental health services at San Quentin Prison, 1983

Testimony in Toussaint/Wright/Thompson v. Enomoto, Federal District Court in San Francisco, regarding conditions and double-celling in California State Prison security housing units, 1983

Consultant, United States Department of Justice, Civil Rights Division, regarding conditions and mental health services in Michigan State Prisons, 1983-4

Testimony in Arreguin v. Gates, Federal District Court, Orange County, regarding "Rubber Rooms" in Orange County Jail, 1988

Testimony in Gates v. Deukmejian, in Federal Court in Sacramento, regarding conditions, quality of mental health services and segregation of inmates with HIV positivity or AIDS at California Medical Facility at Vacaville, 1989

Testimony in Coleman v. Wilson, Federal Court in Sacramento, regarding the quality of mental health services in the California Department of Corrections' statewide prison system, 1993

Testimony in Cain v. Michigan Department of Corrections, Michigan Court of Claims, regarding the effects on prisoners of a proposed policy regarding possessions, uniforms and classification, 1998

Testimony in Bazetta v. McGinnis, Federal Court in Detroit, regarding visiting policy and restriction of visits for substance abuse infractions, 2000

Testimony in Everson v. Michigan Department of Corrections, Federal Court in Detroit, regarding cross-gender staffing in prison housing units, 2001

Testimony in Jones 'El v. Litscher, Federal Court in Madison, Wisconsin, regarding confinement of prisoners suffering from severe mental illness in supermax, 2002

Testimony in Russell v. Johnson, Federal Court in Oxford, Mississippi, regarding conditions of confinement and treatment prisoners with mental illness on Death Row at Parchman, 2003

Hospital Staff: Alta Bates Medical Center, Berkeley

Journal Editorial Positions:
Free Associations, Editorial Advisory Board
Men and Masculinities, Editorial Advisory Panel
Psychology of Men and Masculinity, Consulting Editor
Juvenile Correctional Mental Health Report, Editorial Board
Correctional Mental Health Report, Contributing Editor

Presentations and Lectures (partial list):

"Expert Testimony on Jail and Prison Conditions." American Orthopsychiatric Association Annual Meeting, San Francisco, March 30, 1988, Panel 137: "How Expert are the Clinical Experts?"

"The Termination of Psychotherapy" Psychiatry Department Grand Rounds, Mills/Peninsula Hospitals, Burlingame, February 24, 1989

"Big Ideas, and Little Ones" American Psychiatric Association Annual Meeting, San Francisco, April, 1989.

"Men in Psychotherapy." Psychiatry Department Grand Rounds, Mills/Peninsula Hospitals, Burlingame, September 29, 1989.

"Psychodynamic Principles and Residency Training in Psychiatry." The Hilton Head Conference, Hilton Head Island, South Carolina, March 15, 1991.

Panelist: "The Mentally Ill in Jails and Prisons," California Bar Association Annual Meeting, Annaheim, 1991.

"The State of the Sexes: One Man's Viewpoint." The Commonwealth Club of California, San Mateo, March 25, 1992.

Keynote Address: "Feminism and the Family." 17th National Conference on Men and Masculinity, Chicago, July 10, 1992.

Panel Chair and Contributor: "Burnout in Public Mental Health Workers." Annual Meeting of the American Orthopsychiatric Association, San Francisco, May 22, 1993.

Panel Chair and Contributor: "Socioeconomic Class and Mental Illness." Annual Meeting of the American Psychiatric Association, San Francisco, May 26, 1993.

"Public Mental Health." National Council of Community Mental Health Centers Training Conference, San Francisco, June 12, 1993.

Psychiatry Department Grand Rounds: "Men's Issues in Psychotherapy." California Pacific Medical Center, San Francisco, February 24, 1993.

"The Effect of the Therapist's Gender on Male Clients in Couples and Family Therapy." Lecture at Center for Psychological Studies, Albany, California, April 15, 1994.

"Pathological Arrhythmicity and Other Male Foibles." Psychiatry Department Grand Rounds, Alta Bates Medical Center, June 7, 1993.

Roger Owens Memorial Lecture. "Prisons and Mental Illness." Department of Psychiatry, Alta Bates Medical Center, March 6, 1995.

Keynote Address: "Understanding Our Audience: How People Identify with Movements and Organizations." Annual Conference of the Western Labor Communications Association, San Francisco, April 24, 1998.

"Men in Groups and Other Intimacies." 44th Annual Group Therapy Symposium, University of California at San Francisco, November 6, 1998.

"Men in Prison." Keynote, 24th Annual Conference on Men and Masculinity, Pasadena, July 10, 1999.

"Trauma and Posttraumatic Stress Disorder in Prisoners" and "Prospects for Mental Health Treatment in Punitive Segregation." Staff Training Sessions at New York State Department of Mental Health, Corrections Division, at Albany, August 23, 1999, and at Central New York Psychiatric Institution at Utica, August 24, 1999.

"The Mental Health Crisis Behind Bars." Keynote, Missouri Association for Social Welfare Annual Conference, Columbia, Missouri, September 24, 1999.

"The Mental Health Crisis Behind Bars." Keynote, Annual Conference of the Association of Community Living Agencies in Mental Health of New York State, Bolton Landing, NY, November 4, 1999.

"Racial and Cultural Differences in Perception Regarding the Criminal Justic Population." Statewide Cultural Competence and Mental Health Summit VII, Oakland, CA, December 1, 1999.

"The Criminalization of the Mentally Ill," 19th Annual Edward V. Sparer Symposium, University of Pennsylvania Law School, Philadelphia, April 7, 2000.

"Mentally Ill Prisoners." Keynote, California Criminal Justice Consortium Annual Symposium, San Francisco, June 3, 2000.

"Prison Madness/Prison Masculinities," address at the Michigan Prisoner Art Exhibit, Ann Arbor, February 16, 2001.

"The Mental Health Crisis Behind Bars," Keynote Address, Forensic Mental Health Association of California, Asilomar, March 21, 2001.

"Madness & The Forensic Hospital," grand rounds, Napa State Hospital, November 30, 2001.. Commencement Address, The Wright Institute Graduate School of Psychology, June 2, 2002.

"Mental Illness & Prisons: A Toxic Combination," Keynote Address, Wisconsin Promising Practices Conference, Milwaukee, January 16, 2002.

"The Buck Stops Here: Why & How to Provide Adequate Services to Clients Active in the Criminal Justice System," Annual Conference of the California Association of Social Rehabilitation Agencies, Walnut Creek, California, May 2, 2002.

"Prison as Trauma: For the Prisoner, the Family and the Whole Community," Keynote Address, annual meeting of the International Association of Forensic Psychotherapy, Dublin, Ireland, May 20, 2005.

Books Published:

Public Therapy: The Practice of Psychotherapy in the Public Mental Health Clinic. New York: Free Press/ MacMillan, 1981.

Ending Therapy: The Meaning of Termination. New York: New York University Press, 1988.

(Editor): Using Psychodynamic Principles in Public Mental Health. New Directions for Mental Health Services, vol. 46. San Francisco: Jossey-Bass, 1990.

La Conclusione della Terapia: Problemi, metodi, conseguenze. Rome: Casa Editrice Astrolabio, 1992. (trans. of Ending Therapy.)

Revisioning Men's Lives: Gender, Intimacy and Power. New York: Guilford Publications, 1993. (trans. into Chinese, 2000).
Prison Madness: The Mental Health Crisis Behind Bars and What We Must Do About It. San Francisco: Jossey-Bass/Wiley, 1999.
(Co-Editor): Prison Masculinities. Philadelphia: Temple University Press, 2001.

Other Publications:

"The Depression of Tuberculin Delayed Hypersensitivity by Live Attenuated Mumps Virus," Journal of Pediatrics, 1970, 76, 716-721.
Editor and Contributor, An Ecological Approach to Resident Education in Psychiatry, the product of an NIMH Grant to the Department of Psychiatry and Human Behavior, Drew Medical School, 1973.
"Contact Between the Bars - A Rationale for Consultation in Prisons," Urban Health, Vol. 5, No. 1, February, 1976.
"Schizophrenia and History," Free Associations, No. 5, 1986, 79-89.
"The Dual Potential of Brief Psychotherapy," Free Associations, No. 6, 1986, pp. 80-99.
"Big Ideas, and Little Ones," Guest Editorial in Community Mental Health Journal, 1990, 26:3, 217-220.
"Feminist Men," Tikkun, July/August, 1990.
"Pathological Arrhythmicity in Men," Tikkun, March/April, 1991.
"The Public Therapist's Burnout and Its Effect on the Chronic Mental Patient." The Psychiatric Times, 9,2, February, 1992.
"The State of the Sexes: One Man's Viewpoint," The Commonwealth, 86,16, April, 1992.
"Schoolyard Fights." In Franklin Abbott, Ed., Boyhood. Freedom, California: Crossing Press, 1993; Univeristy of Wisconsin Press, 1998.
"Menfriends." Tikkun, March/April, 1993
"Psychotherapy, Neutrality and the Role of Activism." Community Mental Health Journal,1993.
"Review: Treating the Poor by Mathew Dumont." Community Mental Health Journal, 30(3),1994, 309-310.
"The Gender of the Therapist and the Male Client's Capacity to Fill Emotional Space." Voices, 30(3), 1994, 57-62.
"Soft Males and Mama's Boys: A Critique of Bly." In Michael Kimmel, Ed., The Politics of Manhood: Profeminist Men Respond to the Mythopoetic Men's Movement (And Mythopoetic Leaders Respond). Philadelphia: Temple University Press, 1995.
"Gender Bias, Countertransference and Couples Therapy." Journal of Couples Therapy, 1995.
"Jail and Prison Rape." TIE-Lines, February, 1995.
"The Politics of Psychiatry: Gender and Sexual Preference in DSM-IV." masculinities, 3,2, 1995, reprinted in Mary Roth Walsh, ed., Women, Men and Gender, Yale University Press, 1997.
"What Do Men Want?, review of M. Kimmel's Manhood in America. Readings, 10, 4, 1995.
Guest Editor, issue on Men's Issues in Treatment, Psychiatric Annals,2,1, 1996.
"Men at Work and Out of Work," Psychiatric Annals, 2,1, 1996.
"Trauma and its Sequelae in Male Prisoners." American Journal of Orthopsychiatry, 66, 2, 1996, 189-196.

"Consultation to Residential Psychosocial Rehabilitation Agencies." Community Psychiatric Practice Section, Community Mental Health Journal, 3, July, 1996.

"Shame and Punishment: Review of James Gilligan's Violence: Our Deadly Epidemic and its Causes," Readings, Sept., 1996.

"Community Mental Health: A Window of Opportunity for Interracial Therapy," Fort/Da, 2,2,1996.

"Men, Prison, and the American Dream," Tikkun, Jan-Feb., 1997.

"Dependency and Counter-Dependency in Couples," Journal of Couples Therapy, 7,1, 1997, 39-47. Published simultaneously in When One Partner is Willing and the Other is Not, ed. Barbara Jo Brothers, The Haworth Press, 1997, pp. 39-47.

"Shall We Overcome: Review of Jewelle Taylor Gibbs' Race and Justice," Readings, December, 1997.

"The SHU Syndrome and Community Mental Health," The Community Psychiatrist, Summer, 1998.

"Review of Jerome Miller's Search and Destroy," Men and Masculinities, 1, 1, July, 1998.

"Will Building More Prisons Take a Bite Out of Crime?," Insight, Vol. 15, No. 21, June 7, 1999.

"The Mental Health Crisis Behind Bars," Harvard Mental Health Letter, July, 2000.

"Mental Health Police?," Readings, June, 2000.

"The Men's Movement in the U.S.A.," in Nouvelles Approches des Hommes et du Masculine, ed. Daniel Weizer-Lang, Les Presses Universitaires du Mirail, Toulouse, France, 2000.

"Symptoms, Meanings and Social Progress," Voices, 36, 4, 2000.

"Psychotherapy with Men in Prison," in A New Handbook of Counseling & Psychotherapy Approaches for Men, eds. Gary Brooks and Glenn Good, Jossey-Bass, 2001.

"A Very Wise Decision by the Montana Supreme Court," Correctional Mental Health Report, 5,3, 35-36, Sept./Oct, 2003.

"Review of William Roller's The Dead are Dancing," Psychiatric Services, 54,11,1660-1661, 2003.

"Foreword," David Jones (ed.): Working with Dangerous People: The Psychotherapy of Violence, Oxon, UK: Radcliffe Medical Press Ltd., 2004.

"Malingering in Correctional Settings," Correctional Mental Health Report, 5, 6, 81-, March/April, 2004.

"Mental Illness," in Men & Masculinities: A Social, Cultural, and Historical Encyclopedia, Eds. Michael Kimmel and Amy Aronson, Santa Barbara: ABC Clio, 2004, pp. 537-539.

"Prisons," in Men & Masculinities: A Social, Cultural, and Historical Encyclopedia, Eds. Michael Kimmel and Amy Aronson, Santa Barbara: ABC Clio, 2004, pp. 630-633.

"Posttraumatic Stress Disorder (PTSD) in Prisoners," in Managing Special Populations in Jails and Prisons, ed. Stan Stojkovic, Civic Research Institute, Kingston, NJ, forthcoming 2005.

"Schizophrenia, its Treatment and Prison Adjustment," in Managing Special Populations in Jails and Prisons, ed. Stan Stojkovic, Civic Research Institute, Kingston, NJ, forthcoming 2005.

"Toxic Masculinity as a Barrier to Mental Health Treatment in Prison," Journal of Clinical Psychology, 2005.

B

APPENDIX B

DEPOSITIONS AND TESTIMONY IN THE PAST FOUR YEARS

Deposition in Snow v. Ukiah, U.S.Dist. Ct., No. Dist. Of California, Case No. C99-3669 TEH, February 2, 2001, regarding quality of mental health services in local detention facility

Testimony in Everson et al., v. Michigan Department of Corrections, U.S. Dist. Ct., Eastern Dist. Of Michigan, So. Division, No. 0073133, February 16, 2001, regarding gender and employment in women's prisons (and deposition)

Testimony in Jones 'El v. Litscher, U.S. Dist. Ct., Western Dist. Of Wisconsin, No. 00-C-421-C, September 20, 2001, preliminary injunction regarding confinement of prisoners suffering from severe mental illness in supermaximum prison at Boscobel

Testimony in Robert Charles Comer v. Terry Stewart, U.S. Dist. Ct. for the District of Arizona, No. CV-94-1469-PHX-ROS, post-conviction capital case (and deposition)

Deposition in Westchester Co. Correction Officers Benevolent Assoc., et al. v. County of Westchester, et al., U.S. Dist. Court, New York, No. 99 CV 11685 (SHS), May 14, 2002, regarding gender and employment in women's local detention facility

Deposition in Groot et al. v. Hudson et al., U.S. Dist. Court, No. Dist. of Mississippi, Eastern Div., No. 1:101CV366-JAD, October 2, 2002, regarding possible retaliation and resulting psychological harm in Mississippi Department of Corrections

Testimony in State of Indiana v. Shaka Shakur, Cause No. 45G04-0201-FA-00002, January 29, 2003, Crown Point, felony case

Testimony in Russell v. Johnson, Federal Court in Oxford, Mississippi, regarding conditions of confinement and treatment prisoners with mental illness on Death Row at Parchman, February 6, 2003

Testimony in Groot et al. v. Hudson et al., U.S. Dist. Court, No. Dist. of Mississippi, Eastern Div., No. 1:101CV366-JAD, March 14, 2003, re: damages in individual case.

Deposition in Falkenburg v. Yolo County, Case No. CIV.S-01-1478 DFL GGH, July 30, 2003, regarding jail suicide.

Deposition in Castillo v. Alameida, et al., Case No. C94-2847 MJJ, U.S. Dist. Ct., No. Dist. Cal Oct. 17, 2003, regarding gang validation in Calif. Dept. of Corr.

Deposition in Rasho et al vs. IL DOC et al., Case No. 00-528-DRH, U.S. Dist. Ct., So. Dist. Of East St. Louis Div., regarding conditions of confinement and mental health treatment at Tamms Unit.

Testimony in State v. Saucedo, Case No. CC057550, Santa Clara Co. Sup. Ct., California, Oct. 2004, regarding mental state at time of crime

Testimony in Manning v. Dye, Case No. 02 C 0372, U.S. Dist Ct, No Dist IL, December 10, 20 regarding psychiatric sequelae of term on Death Row for individual who was not guilty

Testimony in State v. Adam Lowe, Ventura County Superior Court, California, January 28, 20C mental state at time of offense

Deposition in Keith Johnson v. Richard Wathen, et al., No. 7:02CV087-M, US Dist. Ct., No. Dist. Of Texas, Oakland, CA, April 21, 2005, regarding effects of sexual abuse in prison

C

Documents Reviewed by Dr. Terry Kupers

Bates Range	Description
Inmate Mental Health Records	
OMHPR 0051699 - 0051817	List of 217. Inmates
OMHPR 0558251-0558386	
PL 009389 – 009613	
OMHPR 0220214-0220438	
OMHPR 0001315 - 0001384 OMHPR 0031792 - 0032299	
OMHPR 0111333-0111401	
OMHPR 0034197 - 0034269; OMHPR 0488307-0488944; OMHPR 0577007-0577651	
OMHPR 0066573 – 0066823	
PL 002230 - 036214	
OMHPR 0592347-0592734	
OMHPR 0439481-0439642	
OMHPR 0260774-0260910 OMHPR 0270938-0271390	
OMHPR 0050794 – 0050869	
OMHPR 0042266 – 0042304; OMHPR 0439306-0439370	
PL 019074 – 019422	
OMHPR 0446823-0447354; OMHPR 0477766-0477982	
OMHPR 0308448-0308482	
OMHPR 0034270 - 0034590; OMHPR 0500034-0500421; OMHPR 0527477-0527828	

Bates Range	Description
OMHPR 0276415-0276501; OMHPR 0425469-0425750	
OMHPR 0568014-0568757	
OMHPR 0002122 – 0003751; OMHPR 0051850 – 0055472; OMHPR 202652-0205417; OMHPR 464195-0466901; OMHPR 474017-0476852	
OMHPR 0247971-0248599 OMHPR 0261702-0261867	
OMHPR 0257890-0258559 OMHPR 0260524-0260773	
OMHPR 0021907 – 0022829; OMHPR 0049129 – 0049303; OMHPR 0083017 – 0084447; OMHPR 0262048-0262245; OMHPR 0701532-0701853	
OMHPR 0579253-0579655; OMHPR 0601947-0602030	
OMHPR 0104212 – 0106447; OMHPR 0327657-0331244	
OMHPR 0043687 – 0044353; OMHPR 0311241-0312497; OMHPR 0313208-0313589	
OMHPR 0604012-0604291	
OMHPR 0548806-0549253, OMHPR 0584768-0585062	
OMHPR 0566983-0567776	
OMHPR 0259429-0259610 OMHPR 0267897-0268783	
PL 004381 - 004443	
OMHCNY 048953 – 049213; OMHPR 0495048-0495180; OMHPR 0526428-0526735	

Bates Range	Description
OMHPR 0034591 – 0034633; OMHPR 0471158-0471506	
OMHPR 0539814-0540310	
PL 002095 –PL 002386; PL 004886 – PL 005577; OMHPR 0003914 – 0004373	
OMHPR 0051034 – 0051254	
OMHPR 0004374 – 0004541	
OMHPR 0050395 – 0050793	
OMHPR 0458453-0458750; OMHPR 0460275-0461070	
OMHPR 0005237 – 0005412; OMHPR 0085258 – 0085488	
OMHPR 0543165-0543333; OMHPR 0605737-0605957	
OMHPR 0262446-0262671	
OMHPR 0045416 – 0045609	
OMHPR 0584221-0584394	
OMHPR 0433056-0433165; OMHPR 0594429-0594457	
OMHPR 0028607 – 0029009	
OMHPR 0552831-0553902, OMHPR 0554842-0555199	
PL 010364 - PL 034825	
OMHPR 0471714-0472557	
OMHPR 0220439-0220507	
OMHPR 0221028-0221057	
OMHPR 0293842-0293988 OMHPR 0295473-0295633; OMHPR 0451015-0452947	

Bates Range	Description
OMHPR 0550464-0550718	
OMHPR 0139419-0139639	
OMHPR 0110937-0110998	
OMHPR 0692259-0692642	
PL 009614 –PL 010446	
PL 028320 –PL 028645	
OMHPR 0537927-0537992	
OMHPR 00076431-0077199	
PL 026695 – PL 026878	
PL 011633 - PL 011705	
PL 028646 – PL 028897; OMHPR 0006875 – 0007387; OMHPR 0232343-0234482; OMHPR 0712252-0713137; OMHPR 0729453-0729631	
OMHPR 0565126-0566981; OMHPR 0570244-0571585	
OMHPR 0034921 – 0035021; OMHPR 0496446-0497430; OMHPR 0527196-0527476; OMHPR 0530656-0530735	
OMHPR 0064640 – 0065024; OMHPR 0529929-0530034; OMHPR 0530165-0530655; OMHPR 0579656-0580115	
OMHPR 0577652-0577873	
OMHPR 0599211-0599573	
OMHPR 0293648-0293841	
OMHPR 0038402 – 0038584; OMHPR 0387912-0388061	
OMHPR 0076416-0076430	

Bates Range	Description
OMHPR 0217333-0217392	
OMHPR 0439643-0442624	
OMHPR 0089544 – 0089890; OMHPR 0258757-0258978; OMHPR 0281506-0282813; OMHPR 0698877-0699236; OMHPR 0730830-0731007	
OMHPR 0508118-0510744; OMHPR 0553903-0554157	
OMHPR 0249770-0250290 OMHPR 0272203-0272745	
OMHPR 0397343-0397375	
PL 014428 - PL 014484	
OMHPR 0051425 – 0051698	
OMHPR 0062440-0062834	
OMHPR 0111769-0111890	
OMHPR 0045681 – 0048380; OMHPR 0084771 – 0085257	
OMHPR 0293989-0294136 OMHPR 0295327-0295472 OMHPR 0439062-0439305	
OMHPR 0246126-0247575	
OMHPR 0285270-0285427 OMHPR 0287230-0287543; OMHPR 0594026-0594299	
OMHPR 0217551-0218206 OMHPR 0278879-0279985	
OMHPR 0253077-0254874; OMHPR 0597870-0599004	
OMHPR 0041983 – 0042265;	

Bates Range	Description
OMHPR 0385720-0386499 OMHPR 0436973-0437959	
OMHCNY 049675-049811; OMHPR 0523305-0523402; OMHPR 0523683-0524354; OMHPR 0524638-0525666; OMHPR 0525836-0526427	
OMHPR 0572258-0572306, OMHPR 0578592-0578952	
OMHPR 0550181-0550463; OMHPR 0600184-0600535	
PL 014955 - PL 015089	
OMHPR 0540758-0540973	
OMHPR 0041719– 0041982; OMHPR 0388062-0388763	
OMHPR 0259837-0260067 OMHPR 0268947-0270227	
OMHPR 0286016-0286320; OMHPR 0594458-0594753	
PL 008317 – PL 008528; OMHPR 0009240 – 0009546	
OMHPR 0563657-0564070, OMHPR 0583722-0584220	
OMHPR 0082565-0083016	
OMHPR 0051818 – 0051849	
OMHPR 0261868-0262021 OMHPR 0270578-0270937	
OMHPR 0109390-0109432	
OMHPR 0256159-0257769 OMHPR 0258560-0258756	
OMHPR 0294549-0294851	
OMHPR 0179818 –0180218;	

Bates Range	Description
OMHPR 0369919-0370131 OMHPR 0382169-0382385; OMHPR 0696107-0697124; OMHPR 0729824-0730098	
OMHPR 0019845 - 0020298	
OMHPR 0010082 – 0010238; OMHPR 0530736-0531139	
OMHPR 0343550-0343769	
OMHPR 0295951-0296449	
OMHPR 0296651-0297039	
OMHPR 0297238-0297440	
OMHPR 0298003-0298460	
OMHPR 0298724-0299452 OMHPR 0381533-0382168	
OMHPR 0355744-0355823	
OMHPR 0111413-0111515	
OMHPR 0548371-0548805; OMHPR 0571586-0572257	
OMHPR 0607335-0607745	
OMHPR 0050135 – 0050327	
OMHPR 0420115-0420964	
OMHPR 0063109-0063375	
OMHPR 0247576-0247970	
OMHPR 0261061-0261379	
OMHPR 0599574-0599587	
OMHPR 0431504-0431690; OMHPR 0594300-0594428	
OMHPR 0035429 - 0035618; OMHPR 0514164-0515486; OMHPR 0516574-0517287; OMHPR 0528478-0528706	
OMHPR 0109357-0109363	

Bates Range	Description
OMHPR 0515487-0516573; OMHPR 0517288-0517802	
OMHPR 0109576-0109620	
OMHPR 0380874-0381532	
OMHPR 0425751-0426117	
OMHPR 0536630-0536893, OMHPR 0552577-0552830	
OMHPR 0047052 – 0047121	
OMHPR 0585063-0585356; OMHPR 0603495-0603991	
OMHPR 0473800-0474016	
OMHCNY 050383 – OMHCNY 050711	
OMHPR 0537390-0537619; OMHPR 0537887-0537926; OMHPR 0585357-0585904; OMHPR 0541123-0541165	
PL 020924 - PL 021891	
OMHPR 0108397-0109149	
OMHPR 0535817-0536629; OMHPR 0543959-0545441	
OMHPR 0046995 – 0047051	
OMHPR 0249482-0249769	
OMHPR 0271391-0272202	
OMHPR 025770-0257889	
OMHPR 0261380-0261454	
OMHPR 0645056-0645114	

Bates Range	Description
PL 029386 – PL 029724; OMHPR 0013701 – 0013705; OMHPR 0013597 – 0013795	
OMHPR 0440265 – 0442623; OMHPR 0446381 -0446822; OMHPR 0447355 -0448073	
OMHPR 0077200-0077893	
OMHPR 0260911-026160; OMHPR 0435431-0436039; OMHPR 0710053-0710257; OMHPR 0728101-0728378	
OMHPR 0111095-0111332	
OMHPR 0343770-0343840	
OMHPR 0561872-0562331	
OMHPR 0014320 – 0014944 OMHPR 0029615 – 0030634 OMHPR 0030948 – 0031231	
OMHPR 0280711- 0281012 OMHPR 0445325-0445922	
OMHPR 0032300-0032706; OMHPR 0492049-0493272; OMHPR 0495756-0496076; OMHPR 0528930-0529654	
PL 014467 – PL 014514; OMHPR 0015404 - 0015642; OMHPR 0074162-0074969	
OMHPR 0554158-0554841, OMHPR 0586854-0587286	
PL 026575 - PL 026725	

Bates Range	Description
OMPHR 0212865-0214483	
PL 008163 – PL 008316; OMHPR 0015643 - 0016442	
OMHPR 0443980-0445308	
OMHPR 0032707 - 0033043; OMHPR 0517803-0519023	
OMHPR 0397593-0397668	
OMHPR 0547159-0547245, OMHPR 0585905-0586160	
OMHPR 0251720-0251977 OMHPR 0252854-0253076	
OMHPR 0110869-0110907; OMHPR 0645629-0645663	
OMHPR 0602035-0602532	
OMHCNY 051298 – 051497; OMHPR 0321316-0323820; OMHPR 0710258-0710680; OMHPR 0728379-0728527	
OMHPR 0599887-0600183	
OMHPR 0288182-0288383; OMHPR 0594754-0594933	
OMHPR 0550719-0551531, OMHPR 0551732-0552576, OMHPR 0588237-0590326	
OMHPR 0074970-0076054	
OMHPR 0643181-0645008	
OMHPR 0604292-0605736	
OMHPR 0110237-0110304	
OMHPR 0220508-0220801 OMHPR 0221058-0222585 OMHPR 0260068-0260348	

Bates Range	Description
OMHCNY 051735 – 052029; OMHPR 0519024-0520813	
PL 003574 – PL 003845; PL 028562 - PL 029104	
OMHPR 0433720-0434024; OMHPR 0593761-0594025	
OMHPR 0561593-0561871	
OMHPR 0561528-0561592	
OMHPR 0109987-0110151	
OMHPR 0216738-0216970; OMHPR 0382386-0382599	
OMHPR 0449671-0449896, 0450962-0450967, 0452948-0453085	
OMHCNY 052030 – 052116; OMHPR 0438927-0439061	
OMHPR 0251978-0251986	
OMHPR 0262022-0262047	
OMHPR 0248600-0249481	
OMHPR 0259150-0259428	
OMHPR 0272746-0273629	
OMHPR 0522386-0522731; OMHCNY 052117 –052338	
OMHPR 0110225-0110236	
OMHPR 0315210-0315431	
OMHPR 0106448-0107896	
OMHPR 0281100-0281262	
OMHPR 0313819-0314040	
OMHPR 0314396-0314457	
OMHPR 0314679-0314978	

Bates Range	Description
OMHPR 0397094-0397342	
OMHPR 0042305 - 0042746	
OMHPR 0042747 - 0043170	
OMHPR 0065578-0065855	
OMHPR 0110152-0110160	
OMHPR 0386500-0387911	
OMHPR 0050870 - 0051033	
OMHPR 0512788-0512840	
OMHPR 0034034 - 0034196; OMHPR 0501234-0501391	
OMHPR 0438644-0438841	
OMHPR 0558948-0559114	
OMHPR 0066847-0067075	
OMHPR 0086290-0088308; OMHPR 0261455-0261701; OMHPR 0695840-0696106; OMHPR 0730289-0730321	
OMHPR 0033698 - 0033805	
OMHPR 0496265-0496274; OMHPR 0562733-0563437	
OMHPR 0222586-0227406; OMHPR 0378978-0379370; OMHPR 0427622; OMHPR 0430971-0431382; OMHPR 0432622-0433055; OMHPR 0590327-0590836	
OMHPR 0569465-0569775	
PL 003846 – PL 004642; PL 046351 - PL 047138; OMHPR 0018442 - OMHPR 0019622; OMHPR 0170713-0173083 OMHPR 0175713-0176928	

Bates Range	Description
OMHPR 0549528-0549900	
OMHPR 0051255 - OMHPR 0051424	
OMHPR 0067076-0069992; OMHPR 0658513-0659183, 0661548-0663541	
OMHPR 0250291-0250725	
OMHPR 0278480-0278745; OMHPR 0714457-0715220	
OMHPR 0564187-0564225	
OMHPR 0498114-0498208; OMHPR 0498364-0499598	
OMHPR 0583690-0583721	
OMHPR 0355961-0356013	
OMHPR 0049614 - OMHPR 0049742	
OMHPR 0477983-0479939	
Suicide-Related Documents and State Commission of Correction Reports	
SCOC 000344-000345, 000368	List of 52 Inmates
SCOC 000369-000379, 000385, 000398-000404	
PL 000031 – PL 000034	
SCOC 000428-000432	
OMH PR 0009941 – OMH PR 0009948	
SCOC 000466-000468	
SCOC 001646-001649	
SCOC 000474-000476	
SCOC 001650-001658	
SCOC 000507-000511	

Bates Range	Description
SCOC000534-000536	
OMHCNY 0059233 – OMHCNY 0059310; SCOC 000571	
SCOC 000655-000656, 000723-000726	
SCOC 000732-00736	
SCOC 000758, 000777-000779	
SCOC 001462-001466	
PL 000153 – PL 000157	
PL 000358 – PL 000371	
SCOC 00809-000813	
SCOC 00840-000844	
PL 000226 – PL 000240	
SCOC 000873-000875	
OMH PR 0009936 – OMH PR 0009940	
SCOC 000876-000877, 000907	
SCOC 000908-000909, 000949-000952	
SCOC 000960-000963	
PL 032155 – PL 032159	
PL 000286 – PL 000295	
SCOC 001058-001062	
OMHCNY 0059371 – OMHCNY 0059411	
SCOC 001063-001064, 001086	
OMHCNY 0060811 – OMHCNY 0060902; SCOC 001761-001765	

Bates Range	Description
SCOC 001109-001112; OMHCNY 060261-060264	
SCOC 001120-001128	
OMHCNY 0061139 – OMHCNY 0061252; SCOC 001540-001544	
SCOC 001161, 001168-001169	
PL 000358 – PL 000371	
SCOC 001536-001539	
SCOC 001659-001663	
PL 000382 – PL 000392; SCOC 001198-001199, 001223	
SCOC 001240-001245	
OMHCNY 0060685 – OMHCNY 0060810; SCOC 001246-001252, 001436, 001633-001636	
SCOC 001527-001530	
SCOC 001279-001285, 001296	
SCOC 001664-001668	
SCOC 000336-000339	
SCOC 001302-001305	
SCOC 001330-001334, 001359	
SCOC 001360-001362, 001404-001409	
OMHCNY 0059793 – OMHCNY 0059886	
SCOC 001531-001535, 001766-001774	

Bates Range	Description
SCOC 001415-001417	Zamora, Jimmie 98-A-5691
Deposition Transcripts	
	Adams, Maureen, 1/28/04
	Barry, David, 8/17/04
	Bea, Jeffrey 6/16/04
	Carroll, Takarla 2/17/05
	Culkin, John 6/9/04
	Devito, Anthony 6/15/04
	Gordon, Charles 1/20/04
	Greene, Gary 2/4/04
	Herrmann, Charles 6/30/04
	Kellam, Leslie 8/20/04
	Key, Nancy 3/17/04
	Keyser, Sharon 8/19/04
	Klein, Loretta 3/12/04
	Lamy, Frederick 2/25/04
	Langbart, Mitchell 10/22/04
	Lape, William 3/3/04
	Leclaire, Lucien 5/26/04
	Lord, Elaine 2/27/04
	Miraglia, Richard 1/11/05
	Pace, Adele 8/10/04