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ENG site visit 1

I. Overview: Summary of Substantive Findings

This report describes my findings from the first, January 1999, site visit to the Attica SHU and the accompanying document review mandated by the Stipulation in Eng v. Goord, Civ 80-385S. The findings in this report are based upon a review of documents provided by the Office of Mental Health (OMH) and the Department of Correctional Services (DOCS), including OMH records of 25 Attica SHU inmates, as well as upon our January 25, 1999 site visit and conference, and my interviews with thirteen inmates on January 26 and 27, 1999. Appendix A includes a description of the process of inmate selection as well as a list of the documents referenced in this report.

As described in the body of this report, although this site visit revealed in some areas clear evidence of efforts to improve clinical services and to bring them into compliance with the Eng stipulation, overall, my conclusions are that while these changes have resulted in some procedural changes, there has not been substantively meaningful improvement in those services, and that the Attica SHU has not moved in any clinically meaningful way towards compliance. The most important deficiencies remain:

1. The psychiatric evaluation and periodic monitoring of mentally ill Attica SHU inmates are grossly inadequate; seriously mentally ill inmates continue to be housed in SHU, and often psychiatrically deteriorate as a result of the stringent conditions of confinement prevailing there.

2. Moreover, despite some examples of compassionate and respectful treatment of SHU inmates, there is a continuing predilection to view inmate behavior as "manipulative" and hence of no cause for serious concern. This characterization, often made without any meaningful effort at evaluation and differential diagnosis, often results in staff dismissing and ignoring symptoms of severe mental illness. Moreover, this characterization fails entirely to recognize that a "manipulation" may well be a desperate, panic stricken cry for help from someone who can no longer bear his emotional state.

3. Perhaps most centrally, the psychiatric treatment available to Attica SHU inmates remains grossly inadequate.

In the SHU itself, there is no opportunity whatsoever for private, individual psychotherapy, let alone any other form of expressive therapy, or group, occupational, or recreational therapy. The only "therapy" provided is brief, cell-side chats with the unit counselor, conducted as part of his "rounds" on the SHU. Medications are offered, but there is no meaningful opportunity for inmates to develop a trusting relationship with the unit psychiatrist, and little or no meaningful effort to engage them in such a relationship; thus, inevitably, medication non-compliance is rampant. When an inmate becomes clearly incapable of tolerating SHU, the only alternative offered at Attica is confinement in isolation to an observation cell in the OMH Satellite Unit. Such confinement, however, does not provide any amelioration of the inmate's conditions; indeed, in many ways it involves <u>more</u> deprivation than exists in the Attica SHU cells - including deprivation of clothing, bedding, or any personal effects or reading material.

> Inmates who are deemed to be incapable of remaining at Attica are sometimes subject to psychiatric commitment to Central New York Psychiatric Center (CNYPC). Yet the "revolving door" pattern of psychiatric deterioration in SHU, leading to transfer to CNYPC, only to once again result in another round of SHU confinement and decompensation, remains apparently as prevalent today as it was at the time of the initial preliminary injunction in Eng. No meaningful review is made at the time of CNYPC discharge to prevent such an occurrence. More pivotal, perhaps, in explaining this failure is the fact that no long-term treatment and housing options have been developed for the recurrently ill, recurrently behaviorally disruptive, Attica SHU inmate.

These deficiencies were present in many of the charts and documents that I reviewed, and in information gleaned from our tour and inmate interviews. The next section of this report describes my findings with respect to eight (8) of these inmates.

In order to prevent this report from becoming overly lengthy, I have not attempted to describe all of the inmates whom I interviewed or whose charts I reviewed. Instead, with one exception, I will simply describe my evaluation of the first seven (7) of inmates whom I interviewed during this visit. This group is not, therefore, preselected to demonstrate any particular finding. Moreover, since this group does not include any inmate whose record I reviewed but who was not housed in the Attica SHU at the time of my visit, it does not include any inmate who was transferred to CNYPC and hospitalized at the time of the tour; this excludes some of the most dramatic cases of mental illness among the inmates whose records I reviewed.[1] The review of Inmate B -

[1] According to information provided at Attica, five of the inmates, whose records I reviewed for this report, were hospitalized at CNYPC at the time of the tour.

the first inmate we interviewed - is especially lengthy, and is organized in part in order to point attention to particular deficiencies. The selection of this inmate for such lengthy review was, again, essentially random.

The one exception to the above-described process of selection is the case of Inmate A, an inmate who committed suicide while housed in the Attica SHU during the period of time under review in this site visit. In my opinion, Inmate A's course is, unfortunately, particularly paradigmatic of the continued deficiencies in the treatment of mentally ill inmates in the Attica SHU.

II. The Suicide of Inmate A

Inmate A committed suicide on May 4, 1998, while housed in the Attica SHU. His treatment, and the postmortem review of his death by OMH staff, unfortunately demonstrate some of the same very basic deficiencies which initially gave rise to the Eng lawsuit some thirteen years previously - the suicide of inmate Inmate Z.

My review of the 1985 suicide of Inmate Z, as well as my review of many more inmate records, discussed in my April 1996 declaration in the Eng lawsuit, revealed an attitude of gross indifference on the part of staff towards very serious mental health problems at the Attica SHU:

1. Inmate psychiatric evaluations were grossly inadequate, with no real attempt being made to review earlier evaluations for incorporation into a coherent diagnostic formulation and treatment plan.

2. There was a "revolving door" of SHU inmates decompensating, being sent to a psychiatric unit (either PSU or CNYPC) until they recompensate, only once again to be returned to SHU, where they would, predictably, once again decompensate.

3. There was too great a pull towards seeing inmate behavior as manipulative, and to uncritically - reflexively - view inmates as "malingering," without any meaningful attempt at psychiatric evaluation -- even utterly disregarding the existence of prior records clearly documenting serious psychopathology, and even utterly disregarding the fact that at the very same time that the inmate was being diagnosed as "malingering," he was <u>simultaneously</u> on high doses of potentially toxic antipsychotic medication.

Inmate Z's record revealed that he had a history of severe mental illness - depression with suicidal and psychotic features, and a history of three actual suicide attempts while housed at Attica SHU, prior to his successful suicide in June 1985. He had been subjected to a "revolving door" of decompensation, leading to restabilization at CNYPC, where he would become calm, non-psychotic and treatment compliant. Then, following discharge from CNYPC, he would be almost immediately returned to his SHU cell at Attica, where, predictably, he would become increasingly agitated and fearful, and then, inevitably, stop being compliant with his medication and once again decompensate. It was shortly after a transfer back to Attica SHU from CNYPC that he successfully suicided by hanging. Prior to his death, he had once again decompensated; he became fearful and agitated, refused to eat, shave or shower, and threatened to kill himself if he were not given relief. His increasing paranoia, agitation, and suicidality were all ignored; indeed, all of these manifestations of his desperation - even, grotesquely, his ultimate successful suicide - were all characterized by the mental health staff at Attica as "manipulative."

Inmate Z's death, his course while at Attica SHU, and the staff's indifference to his suffering, are eerily parallel to the history revealed in Inmate A's record. His record indicates that his treatment at Attica SHU suffered from all of the gross deficiencies which initially gave rise to the Eng lawsuit, and that his death was a product of this gross indifference to his mental health needs.

1. **Inmate A's Psychiatric Illness and Course at Attica SHU.**

Note: Usage and Citation.

The history which follows is largely taken from Inmate A's OMH medical record; when the record is not directly quoted, it is being paraphrased. At those times when I am extrapolating from, or reaching my own conclusions based upon, those records, this fact will be explicitly stated.

Inmate A's OMH record is quite spotty and often grossly inadequate, it does provide enough information to demonstrate the following:

He had a history of severe emotional problems since childhood, and had lived in various State Institutions since he was six years old. His uncle had also suffered from mental illness, and Inmate A had been physically abused as a young child - prior to his institutionalization. In 1981, when he was still only twelve years old, he was apparently suffering from serious depression and suicidality; as a result, he was psychiatrically hospitalized for four months at King's County Hospital.

Inmate A had continuing, severe mood problems, and made several documented suicide attempts while in custody - including by hanging and cutting himself - before July 1997, when he was transferred to the Attica SHU. The OMH record clearly notes some periods of time since 1991, when he was initially incarcerated, during which Inmate A appeared to be functioning without overt evidence of major psychiatric disturbance. It also, however, quite clearly demonstrates that during his incarceration,

Inmate A suffered recurrently with periods of florid psychotic illness, marked by intense agitation, manic activity, affect and behavior, from pressured speech, marked fearfulness, paranoia, and overt delusions, along with visual and auditory hallucinations, and disorganization of thought and confusion - these latter at times reaching the level of utter incoherence. These episodes were thought variously by OMH staff to represent either a severe - Psychotic - Bipolar Mood Disorder (Manic Depressive Illness) or else some other, unspecified, psychotic disorder.

Such observations of psychotic illness, and of the prescription of antipsychotic medication, occur periodically in Inmate A's OMH record, and were a virtual constant during the entire period of Inmate A's incarceration in Attica SHU - a period of incarceration which began in July 1997, and except for an interruption by his psychiatric hospitalization at Central New York Psychiatric Center (CNYPC) from February through March 1998, continued up until his suicide on May 4, 1998.

A detailed review of Inmate A's OMH record prior to his return to Attica on March 19, 1998 is contained in Appendix B to this report.

While I have not reviewed Inmate A's complete CNYPC inpatient record, the discharge summary from this admission is included in Inmate A's Attica OMH record. This summary reveals that on admission Inmate A presented in a floridly manic state. He was agitated, impulsive, hyperactive, emotionally volatile and explosive. His speech was pressured, his thinking illogical and psychotically disorganized, and he was paranoid, hallucinating, and delusional. As before, the differential diagnosis was between an Unspecified Psychotic Disorder and a Psychotic Manic Bipolar Disorder.

Inmate A's remained severely ill and agitated during much of that hospitalization, and required both physical and chemical restraints[2]

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2 "Chemical restraints" refers to the involuntary - usually intramuscular - administration of potent antipsychotic and/or sedative medications in order to aid in the

restraint of a disturbed patient's agitated and dangerous behavior; this procedure is only justifiable in an emergency situation.

to contain his agitated, violent psychotic behavior. He was terrified that correctional staff were attempting to kill him, and was agitated and violent towards staff at CNYPC.

Gradually, however, his clinical state did improve during this hospitalization, and by the time of discharge, it was markedly improved. At discharge he was described as no longer manifesting any symptoms of active psychosis, and he was calm enough and trusting enough to have agreed to cooperate in taking prescribed psychotropic medications. He was discharged on March 19, 1998 on both an antipsychotic - Risperdal - and the mood-stabilizing, anti-manic drug, Depakene.

At discharge from CNYPC, Inmate A was transferred back to Attica. The Eng Stipulation called for Inmate A to have an OMH assessment and for the OMH staff to clinically determine, because he had previously deteriorated while in SHU, whether he could be placed in the SHU. Stipulation IB. His treatment plan from CNYPC was to continue unless modified during a treatment plan review. Stipulation IE2, 3. Yet no such evaluation was made; on transfer, he was initially admitted to a Mental Observation cell in the Psychiatric Satellite Unit, and the very same day - March 19 - he was transferred back to SHU.

Contrary to the requirements of the Stipulation, there is no record of any consideration of any CNYPC discharge treatment recommendations - except continuation of the medications he was being prescribed at the time of discharge. The CNYPC discharge recommendations included: "Therapy/Counseling: The patient should receive supportive counseling in the correctional facility to help him learn and better cope in that environment. Educational/Vocational: Both types of programming are recommended." The Attica OMH record, however, reveals no consideration of the whole issue of treatment planning and housing recommendations upon return to Attica from CNYPC. Indeed, the OMH note of March 19 justifying Inmate A's transfer from Mental Observation back to SHU is sparse to the point of meaninglessness: "Just

returned from CNYPC. He doesn't respond verbally when talked to but did use some very clear hand gestures. He is to be discharged from MHU and sent to SHU."

Within days of his reincarceration in Attica SHU - on March 23, 1998 - he was once again agitated, non-compliant with his psychiatric medications, and reporting auditory and visual hallucinations. The OMH response was to move him to a Mental Observation cell and to involuntarily medicate him with an intramuscular injection of a potent antipsychotic - Haldol - which has a high incidence of adverse side effects. He was returned to SHU that same day.

Four days later, March 27, Inmate A remained non-compliant with medication. He evidenced paranoia; the OMH note from that date states that Inmate A had kept the mashed potatoes from a meal in a paper bag, and had then attempted that day to hand them to the mental health counselor who was doing rounds on the SHU. Inmate A apparently pleaded with the counselor to take the bag and check the potatoes - apparently convinced that the counselor could thus discover that the potatoes were, indeed, poisoned. Then he handed the counselor a note threatening to kill himself. The counselor's progress note of that date demonstrates many of the very same ethical and clinical deficiencies which originally gave rise to the Eng litigation. There was an excessive concern with the possibility of "malingering" and "manipulation," and a grossly inadequate concern for the possibility that Inmate A was actually psychiatrically decompensating and at serious risk:

1. The OMH note states that although Inmate A denied that he wanted to return to CNYPC, he was making this suicide threat only to manipulate his way out of SHU and to return to CNYPC. In support of this proposition, the counselor noted that Inmate A had in fact just returned from a hospitalization at CNYPC, and that his current behavior was simply a continuation of the concerns which led to that hospitalization: "Inmate was sent to CNYPC to evaluate whether he was really psychotic or if he is just

manipulating to get transferred. After return, the patient continues to threaten to hurt himself if not sent back to CNYPC."

Yet this March 27 OMH progress note says nothing at all about what was actually found at CNYPC. Instead, the specious "logic" in the note is the proposition that the very fact that the issue of malingering had even been raised at the time of Inmate A's commitment to CNYPC was proof enough that he was only a manipulator.

The CNYPC record had revealed nothing of the kind. It had revealed that Inmate A was extremely psychotic, very agitated, very impulsive, and very difficult to restore to any semblance of normal functioning - even in the hospital setting. Moreover, the conclusion that he suffered from a Psychotic Bipolar Mood Disorder clearly was part of the discharge evaluation; not only was it explicit in the discharge diagnosis, but also, Inmate A was discharged from CNYPC on both antipsychotic and anti-manic drugs.

In short, the March 27 OMH note reveals a continuing, and utterly indefensible, predilection on the part of Attica OMH staff to consider even the merest whiff of the possibility of "manipulation" as proof that they are dealing with only - exclusively - manipulation, and that this manipulation - actually thus synonymous with "malingering" - is not borne out of agony and desperation.

There is a very distasteful and self-serving aspect to this predilection. For if the behavior was "just manipulation," then there was nothing the OMH staff had to do about it. There was no responsibility - no accountability - for it.

2.   According to the Eng Stipulation, Inmate A could not be returned to or maintained in the SHU if he were "known to be currently suffering from a severe mental disorder or severe depression and . . . currently exhibiting symptomatology which requires immediate treatment/evaluation in a mental health setting or . . . is known to be at substantial risk of serious mental or emotional deterioration." Stipulation IA1.

The March 27 note goes on to say that - although Inmate A is thus already

established as likely being a "manipulator" - even if he is mentally ill, this makes no difference, since his refusal of his medication clearly establishes that: "It has become quite obvious that even if the patient does have a mental disorder, he is not interested in receiving treatment. ... Will discharge to SHU." OMH staff concluded that this inmate who had just written a note and communicated it to OMH staff was "not interested in receiving treatment," even if he was actually ill. Yet clearly, Inmate A was asking for help from OMH - even if his request was psychotic and illogical. This conclusion is also indefensibly cynical and self-serving: Because Inmate A is non-compliant, it no longer matters whether he is severely ill or not, and OMH staff are relieved of any responsibility towards him.

OMH discharged Inmate A back to SHU, indicating that he was not mentally ill and deteriorating but simultaneously they continued to administer involuntary psychotropic medication. Thus OMH staff simultaneously asserted both of the following propositions: 1) Inmate A is not so ill, or not ill at all, which justifies OMH sending him back to SHU and doing virtually nothing to help him; 2) he is so ill that he must be medicated against his will with Haldol - a medication that is so potent and so toxic that it can cause permanent neurologic damage. These two propositions - that Inmate A was not at significant risk, and that Inmate A was a candidate for involuntary medication - are simply and unavoidably contradictory. One proposition - that he is not so ill, or not ill at all - justifies OMH doing virtually nothing to help him. The other - that he can be medicated against his will - justifies their use of chemical restraints, and avoids any need for them to form any trusting, professional relationship - any "therapeutic alliance" - with him.

The OMH notes after March 27 document Inmate A's increasing desperation. He pleaded with staff that he could not stay in his SHU cell because he was being visited nightly in his cell by the judge who sentenced him, and experienced these "visits" with

terror.[3] On April 6, he handed a psychologist, Dr. Pasqual, a note stating that he would hang himself if he did not get out of the cell. Dr. Pasqual's indicated in the chart: "He states that he can't take his cell in SHU anymore and needs to get out."

Inmate A apparently began suffering with severe akathisia[4] as a result of receiving intramuscular injections of Haldol at Attica; the OMH record demonstrates that he became increasingly agitated, restless, and unable for several days to eat or sleep. On April 10, the antihistamine Benadryl, a medication which is often helpful in counteracting this side effect, was finally administered, although it provided only a modest degree of relief.

Just four days later, on April 14, Inmate A attempted to hang himself in his SHU cell. He had torn his bed sheet to use as a rope, tied it around his neck, and then to the bars of his cell. But the sheet ripped, and he lived. When he was discovered, he informed the Correctional staff that "the judge" had ordered him to hang himself.

After this suicide attempt, Inmate A was again transferred to a Mental Observation cell, where he was again involuntarily medicated with intramuscular Haldol. Nothing more was done. Within a day, he was returned to his SHU cell. Two days afterwards, on April 17, he was again refusing to take his medication; he was observed in a deteriorated state - lying on his bunk, mute, his cell littered with garbage, food and paper items. Two days later, on April 19, he was returned to Mental Observation. He

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3 Inmate A had a long-standing delusion concerning the judge who had sentenced him. Inmate A reported at different times that the judge: ordered him to die; arranged for him to be stabbed; and commanded him to kill himself and others. See Appendix B, Inmate A's OMH Record Prior to March 1998.

4 Akathisia is a neuromuscular ("extrapyramidal") side effect of the older antipsychotics such as Haldol. It is characterized by motor restlessness - an inner agitation, a feeling of not being able to be still, a feeling as though the patient is crawling out of his own skin. The intense agitation associated with this side effect can have lethal consequences - precipitating agitated, violent, or suicidal behavior. A critical advantage of the newer antipsychotics, such as Risperdal - the drug prescribed at CNYPC - over these older drugs is their markedly fewer neuromuscular side effects.

reported feeling weak, with no appetite. The tone of his voice was low and at times he could not be understood. He pleaded - <u>in fact</u>, <u>entirely correctly</u> - that the medications being administered to him were affecting him detrimentally; he refused to take any medication, except for the Benadryl which was prescribed to quiet down his akathisia. The record reveals no consideration of this plea, nor of his plea of hopelessness that "nothing will help" - that he simply could not tolerate further confinement in the SHU.

The record states: "The more he thinks about going back to SHU, the more depressed he becomes. He stopped his meds because nothing will help." And it indicates the OMH staff response: " Not currently seen as mentally ill. He has continued posturing to avoid SHU time."   Accordingly, Inmate A was discharged back to the Attica SHU.

Inevitably, within days, on April 24, Inmate A again attempted to hang himself and was once again transferred to Mental Observation. He was almost immediately returned to SHU and nothing more was done.

Three days later, on April 27, he was seen on SHU rounds: "He expressed concern about his mental health. He is having difficulty swallowing and believes it is due to the (long-acting) Haldol he received on April 15."   Inmate A was once again most likely entirely correct in this assessment; the extrapyramidal side effects he suffered with Haldol commonly cause difficulty swallowing.

He continued refusing all medication (oral antipsychotics and Depakene) except Benadryl, and on April 30, he pleaded for an increase in his Benadryl, which apparently was helping both his akathisia and also his inability to sleep. The psychiatrist, Dr. Melendez, refused his request. Apparently, if he would not take his other medication, she would not give him more Benadryl.

This is the last note in his OMH record. Inmate A killed himself at 1:30 a.m. three days later.

2. **Postmortem Review of Inmate A's Death**

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These conclusions and the thinking which underlies them, reveal very much the same major deficiencies which characterized Inmate A's treatment, as well as that of Inmate Z some thirteen years previously.

3.1 Inmate A was Housed in Attica SHU in Violation of the Eng Stipulation

[redacted section]

If at times during the weeks after his discharge from CNYPC and before his death he was not exhibiting florid psychotic symptomatology, this was undoubtedly in part because that symptomatology was being suppressed by powerful antipsychotic drugs.

Inmate A was a gravely ill man, who presented a classic picture of a person who by reason of mental illness was unable to withstand the stresses of prolonged isolated confinement. He was precisely the type of individual contemplated by provision IA1 of the Eng agreement: ". . . [i]n no case shall an inmate who . . . is known to be at substantial risk of serious mental or emotional deterioration, be placed or maintained in SHU."

3.2 Was Inmate A's Suicidal Behavior "Manipulative"?

[redacted section]

Was there a "manipulative" aspect of Inmate A's behavior? Of course there was. There is no doubt that Inmate A was desperate to get out of Attica SHU, and that this desperation drove him to desperate behaviors. But does this fact indicate that the behavior was not driven by serious mental illness and severe, unbearable suffering? Of

course not.

There is a fundamental defect in the staff's reasoning here. It lies in their indifferent confusion of the terms "only manipulating" (i.e. "malingering"), "manipulation," and "secondary gain." In Inmate A's OMH record, all three ("secondary gain," "manipulative," and "only manipulative") are used haphazardly and indiscriminately. Indeed, there sometimes appears to be a progression from one of these terms to another. For example, the Psychological Autopsy documents progress notes in Inmate A's chart: On March 23, 1998, Inmate A's behavior - handing a Social Worker a bag of mashed potatoes and his suicide threat - were deemed examples of "secondary gain." By the next day, March 24, however, this behavior was described as "an attempt to manipulate his way back to CNYPC." Then later that day, an OMH note justifying his continued incarceration in SHU states: "He may continue to exhibit self-harming behaviors but they are only attempts to manipulate his way out of SHU."

This progression of terms - not based upon any change in information or assessment - would seem to suggest that they are interchangeable. But these terms are decidedly not interchangeable. An individual who is not mentally ill may feign such illness in an attempt to manipulate his environment. In such a case, the individual's behavior would properly be described as only a manipulation. But, as the Court found in Madrid v. Gomez (based partly on my testimony in that case): "...[A]n overburdened, and sometimes indifferent, mental health staff [may be] far too quick to dismiss an inmate as a "malingerer" and thus deny him needed treatment. ... Indeed, [this] obsessive preoccupation by staff members with the possibility that an inmate might be manipulating, [often] significantly impairs their capacity to recognize severe mental illness." The Attica OMH record reveals no attempt at distinguishing malingering - the feigning of illness behavior in order to manipulate - from illness behavior which has a manipulative component.

Indeed, Inmate A's record reveals a lack of differentiation even of the terms "manipulation" and "secondary gain." "Manipulation" and "secondary gain" are also not interchangeable, although they appear in Inmate A's record as though they were. "Secondary gain," and its complement - "primary gain" - are psychoanalytic concepts which together provide a conceptual framework within which to analyze the meaning of psychiatric symptoms. The "primary gain" of a symptom was thought of as the utility of that symptom in managing the patient's unconscious feelings and conflicts. The "secondary gain" was described as the symptom's utility in producing actual change in the patient's environment. Thus, both processes were "manipulative" - the "primary gain" represented a manipulation of the internal, intrapsychic world, and the "secondary gain" represented a manipulation of the external world - but both processes were entirely unconscious, and were not susceptible to change without psychological treatment. "Secondary gain" - the term used in the March 23 OMH note - is a concept which can be applied <u>only</u> to cases of genuine psychiatric illness; it can <u>never</u> be used as a construct to describe manipulative behavior which is in the context of <u>feigned</u> illness - of malingering.

On the other hand, the term "manipulation" is not - like "secondary gain" - restricted to <u>unconscious</u> processes; it can also describe the result of a - in part or wholly - conscious process. If Inmate A <u>was</u> truly desperate to get out of SHU because he truly could not tolerate this confinement, this desperation - and the hope that the OMH staff might respond to it - might well have fanned the flames of his suicidal ideation and threats. A patient's desperate need to manipulate his environment can <u>of course</u> result in an increase in behaviors which have the possibility of effecting such a change. The mental process producing an increase in such behaviors might be anywhere along a spectrum from mostly or entirely unconscious to mostly or entirely conscious.

The critical difference is not to what extent such "manipulative" behavior is conscious or unconscious; the critical difference is to what extent the behavior is only the product of a logical calculus of means and ends based upon a rational desire to change one's environment. If an inmate is cooly, rationally malingering - feigning symptoms in order to manipulate his environment - then the staff's refusal to let him out of SHU for his behavior, (or even punishing him for the behavior by imposing additional strictures) , might well result in a change in the parameters of that rational calculus; the inmate may logically decide to forego the behavior.

On the other hand, to the extent that the inmate's "manipulative" behavior is a manifestation of explosive inner emotional turmoil and desperation - to the extent that it is fundamentally irrational - then changing the parameters of some hypothetical rational calculus is very likely not to improve the behavior. Indeed, quite the contrary; it is likely to worsen this fundamentally irrational behavior. If staff response worsens the inmate's desperation, or increases the inmate's hopelessness about escaping it, then the staff's refusal to let him out of SHU for his behavior will not make his behavior more "rational"; it will, instead, more likely result in his behavior becoming more explosively violent. This is precisely what occurred in Inmate A's case.

The record reveals graphically how readily the Attica OMH staff seized upon the fact that Inmate A's behavior might have a manipulative aspect, and how quickly they transformed that observation into a conclusion that his behavior was "only" manipulative: On March 23, 1998, four days after his transfer back to Attica, and in the context of recognizing the potential "secondary gain" of Inmate A's threat of suicide, the Attica OMH staff treated Inmate A as an individual in desperate inner turmoil, administering intramuscular Haldol against his will. Yet within one day - and presumably in the context of Inmate A then being relatively calm because of the administration of this powerful drug - this behavior was redefined as "only

manipulating." Thus, within 24 hours, a psychotic individual manifesting desperate behavior had become, in effect, a malingerer attempting to "con the system."

The callousness demonstrated by this transformation persisted throughout the remaining weeks of Inmate A's life. The record reveals many clear manifestations of Inmate A's mental illness and of his severe suffering, but the staff seems recurrently to have averted its attention from these observations - and from the profound responsibility which the staff should have experienced as a result of such observations - and instead recurrently emphasizes the significance of random observations of moments when Inmate A appeared either coherent or else "manipulative."

This tendency is also revealed in a memo prepared by Bruce Bradigan after Inmate A's death. Mr. Bradigan notes that on April 14,1998, he observed Inmate A with a noose loosely wrapped around his neck, grinning oddly and mute. The only information provided by Mr. Bradigan is that, "based on [INmate A's] recent history and current behavior, he appeared to be manipulating to be removed from SHU." The assessment of Inmate A's possible psychosis and suicidality should have been based upon his entire psychiatric history - not just an "impression" of recent behavior.

Mr. Bradigan's note also indicated that he was then told that - despite this "impression" that Inmate A was only manipulating - he would be sent to a Mental Observation cell for "closer observation." Inmates, such as Inmate A, who are sent to Mental Observation, are generally transferred back to SHU shortly - once they give the "impression" that they are calm and not suicidal. Virtually never is there any "closer" evaluation during such brief MHU confinement.

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But this makes no clinical sense at all. For one thing, Inmate A's lament that MHU was not helping, is not at all surprising; after all, as described elsewhere in this report, the MHU housing at Attica for SHU inmates is even more isolated and barren

than that in the SHU itself. It was not Inmate A's responsibility to find some alternative for himself. All he could state was what he knew - that he could not tolerate SHU, and that the MHU was not helping him. It was not his responsibility to come up with some other alternative to CNYPC. That task was the responsibility of DOCS and OMH.

3.4 Conclusions Regarding Inmate A's Course at Attica.

As stated at the beginning of this discussion of Inmate A's course at Attica, his treatment at Attica SHU is strikingly parallel to that experienced thirteen years previously by Inmate Z. As was the case with Inmate Z, there was striking indifference to Inmate A's plight, and he was subjected to the repeated cycle of a toxic SHU confinement leading to florid psychotic decompensation, transfer to MHU or CNYPC, and then transfer back to SHU. Inmate A's record demonstrates that the OMH staff remain overly preoccupied with a desire to root out malingering and to not be "conned" by the inmates; these preoccupations seem to have overridden their sense of professional responsibility as clinicians.

Inmate A's death was the predictable consequence, foreshadowed by multiple obvious warnings, of a pattern of psychiatric neglect and indifference towards a gravely ill patient - a pattern which should not have been tolerated in any competent institution. He presents a classic picture of the person who by reason of mental illness was unable to withstand the stresses of prolonged isolated confinement, and ultimately succumbed to them fatally.

As is true of many of the inmates whom I have evaluated, Inmate A recompensated when he was hospitalized at CNYPC, with the full range of treatment options available there, but once he was returned to a punitive SHU setting, no meaningful treatment options were provided. There was basically no opportunity for individual psychotherapy, and exceedingly limited opportunity for him to develop any

trusting relationship with a clinician or psychiatrist, despite the explicit directions in the CNYPC discharge summary. In such a circumstance, treatment compliance was, at best, a doubtful proposition. And there is little in his OMH record to suggest that there was ever any meaningful attempt to establish such an alliance.

Moreover, in the hospital setting, Inmate A had the opportunity for group, occupational, recreational and expressive psychotherapies. In the Attica SHU, he had virtually nothing at all.

General population inmates who are at the brink of psychiatric decompensation are housed in Attica's Residential Crisis Treatment Program (RCTP). They are housed together, and have therapeutic opportunities fairly similar to those typically available in a hospital setting. But SHU inmates at Attica who are in need of acute mental observation - such as Inmate A - are housed in an entirely separate area of the Attica Psychiatric Satellite Unit, in utterly barren Mental Observation cells, in isolation, with nothing to divert them from their torment.

Why is the housing so different for these two groups? Because even in this clinically precarious situation, it appears that there is an institutional imperative that SHU inmates must continue to be punished. This is an imperative that I have seen in other institutions, and at other times at Attica, always rationalized by a similar emphasis on inmates' "manipulation" and a corresponding lack of emphasis on the seriousness of their illnesses. Even in Mental Observation, the psychologically ill Attica SHU inmate continues to be psychologically punished. Inmate A "manipulated" his way from one psychologically unbearable setting to another, and his experience of hopelessness and desperation worsened, with ultimately fatal results.

During this Site Visit, senior officials at OMH acknowledged that there is a major structural gap in their treatment options. DOCS <u>has</u> provided - in its Intermediate Care Programs - for the long-term residential housing and treatment of the relatively passive

mentally ill inmate. DOCS has generally experienced no such mandate to provide such long-term residential housing and treatment for disruptive mentally ill inmates. Without such an option, such behaviorally disruptive mentally ill inmates have no meaningful long-term housing option available to them. This was precisely the vacuum which ultimately consumed Inmate A.

III. Other Inmate Reviews.

1. Inmate B

Inmate B, a 25 year old black male who was incarcerated in 1995, was the first inmate I interviewed during the January 1999 site visit. His history was not atypical of that encountered among psychiatrically ill SHU inmates; it included a history of head injury, of borderline intellectual functioning, of severe impulsivity and mood lability, and of acute confusional psychosis during periods of SHU confinement.

He had a history of serious psychiatric difficulties during incarceration, including psychiatric hospitalizations. In October 1995, early in his incarceration, Inmate B was admitted to the psychiatric unit at Bellevue Hospital with auditory hallucinations and depression. He was noted on that admission to be paranoid and fearful, irritable and with pressured speech and disorganized thinking. He was diagnosed as suffering from a psychotic disorder, and was treated with antipsychotic and anxiolytic/mood-stabilizing medication.

One year later, while incarcerated in solitary at Sing Sing, he developed a psychotic delirium, the paradigmatic illness caused by solitary confinement - an acute confusional, paranoid, hallucinatory psychosis, marked by agitation, intense fear and by subsequent amnesia for events of the psychosis. He was transferred to the Mental Health Unit (MHU), where he reportedly recompensated, only then to be transferred

back to SHU, where he apparently once again decompensated into a psychotic state.

Inmate B was transferred to Attica in July 1997, and was transferred to the Attica SHU in October 1997. Inmate B quickly decompensated, and his condition progressively worsened over the following months. In January 1998, he was transferred from his SHU cell to the MHU. He was described by Dr. Melendez as "acting strangely again," just as he had during prior periods of SHU incarceration. He was described as anxious, hyperactive and unable to sit still, and with odd mannerisms, such as blinking his eyelids excessively. He was confused, with psychotically disorganized thoughts and unable to remember anything; he appeared at times to be almost incoherent. Inmate B complained of being unable to sleep, and was noted to have an exaggerated startle response. He was exposing himself and masturbating compulsively, complaining of odd somatic symptoms, such as swelling and pain in his groin.

Dr. Melendez prescribed an antipsychotic medication; despite this, and despite Inmate B's rather floridly psychotic presentation, Dr. Melendez maintained that it was possible that she was being manipulated by her patient: "For the past two years, he acts bizarre every time he gets into trouble and has to do SHU or keep lock."

Over the next month, Inmate B continued to be psychotically ill. He refused his antipsychotic medication, was noted to be yelling and banging, staring blankly, exposing himself and masturbating openly, and was described as agitated, disorganized, labile and paranoid - trying to force himself to stay awake out of fear that he would be attacked at night. For the first several weeks, the only response to this floridly disturbed behavior was further punishment; he was given disciplinary tickets for banging and yelling, and was punished with the restricted diet; he was fed only a food loaf diet.

On February 24, he was committed to CNYPC, where he remained for the next three months. Inmate B's condition improved markedly during this hospitalization and

by the time of discharge, he was compliant with treatment and cooperative with staff. His psychosis had cleared with treatment, including a relatively brief course of the antipsychotic, Risperdal. A mood/impulse control disorder was diagnosed, and he was prescribed the mood stabilizing medication, Depakote, a medication which was expected to be continued after discharge. Donald Moberg, the psychologist who completed Inmate B's Inpatient Core History, noted Inmate B's long history of psychiatric difficulties, and concluded: "Considering Inmate B's continuing psychiatric difficulties, he may be an appropriate candidate for transfer to a continuing care ward." The discharge summary also recommended individual counseling for 30 minutes a week and a psychiatric interview for 10 minutes a week.

Inmate B was discharged from CNYPC back to Attica in May 1998, and was immediately returned to SHU with no apparent consideration of the recommendation that he be housed in a continuing care ward, and in direct violation of the Eng Stipulation's requirement that inmates with serious mental illness or a history of serious psychiatric decompensation in SHU not be housed there. Neither the individual counseling nor the weekly psychiatric interview were provided to him in the SHU. According to a note prepared by Dr. Melendez, upon his transfer back to Attica SHU, he was handed three disciplinary tickets related to his psychotic behavior three months previously. Inmate B protested that he could not even remember the events which transpired during his period of psychosis, but the note indicates that this protest was simply ignored.

Instead, Dr. Melendez' note reflects mostly a continued exaggerated vigilance to the possibility that Inmate B was malingering in order to manipulate his way out of SHU: "Claims he doesn't remember anything happening [in February] and claims he didn't do anything. Today he looks calm and organized. . . Interesting to note that he didn't take any antipsychotics during his stay at Marcy. . . It will be interesting to see what

happens now with how he deals with [the February] tickets."

Dr. Melendez' "interest" apparently concerned the possibility that Inmate B had been feigning mental illness in February rather than in the overwhelming evidence that he had, instead, been floridly psychotic at the time. Her note also reflects a rather cavalier readiness to <u>assume</u> from the fact that Inmate B was not <u>then</u> (in May) on antipsychotics, that such medication had not been required at CNYPC - an assumption which was incorrect - as stated previously Inmate B was treated with the antipsychotic Risperdal for a period at CNYPC.

Moreover, Dr. Melendez' note does not reflect two other possible explanations for Inmate B's current non-psychotic state: first, that Depakote was controlling the affective instability which drove his psychotic state; and second, that Inmate B three months' experience of a therapeutic hospital milieu - as opposed to a toxic SHU environment - had a dramatic effect on his psychiatric state.

Inmate B did not do well - neither with his tickets nor with his clinical state - after his return to Attica SHU. By June 16, he was again overtly psychotic, and once again, he required antipsychotic medication. Dr. Melendez prescribed Zyprexa, a drug reasonably similar to the Risperdal he had received at CNYPC. Despite the obvious implication of prescribing an anti-psychotic - the implication that Inmate B was again decompensating into a psychotic state within weeks of return to SHU - Dr. Melendez did not suggest that Inmate B should be transferred out of SHU. Instead, over the following week, despite the prescription of the antipsychotic, Inmate B continued to further psychiatrically decompensate. By June 23, he was agitated, pacing, crying in his cell, and pleading that being in Attica SHU was, for him, "a slow torture." He was that day recommitted to CNYPC, where he was to remain until September 9, 1998.

He once again recompensated at CNYPC, and once again returned to Attica off of antipsychotics, and back on a mood-stabilizing anticonvulsant - Neurontin - a

medication similar pharmacologically to Depakote.

Once again he was returned to the Attica SHU in violation of the Eng agreement. There is no basis stated in the OMH record for the mental health professional's conclusion that "the inmate may be placed in SHU despite such a history," nor any description of "steps that will be taken to monitor the inmate for a recurrence of such symptoms while he is in SHU." Stipulation IB4. Once again, Inmate B began to psychiatrically decompensate in the SHU; over the next months he became agitated, non-compliant, and began masturbating openly. Dr. Melendez' response was hostile and irritated: "He continues to insist he is right [whether it was his right to masturbate openly] and everyone else is wrong."

I interviewed Inmate B on January 25, 1999. He had been released from Mental Observation a few weeks earlier, and once again had been returned to SHU. During our interview, Inmate B did appear somewhat agitated, but his mental state was clearly not as disturbed as what had been described at other times in his record. He was able to provide additional information about his experience in Attica SHU - information which was confirmed in our interviews with other Attica SHU inmates:

Medication Dispensing

Inmate B explained that there was actually a substantial basis for his refusals of medication. The medication which he was prescribed has a sedating effect and generally is prescribed for nighttime administration. The Attica OMH staff, however, only dispense any medication - even "evening medication" - no later than 1:00 in the afternoon. Inmate B was already struggling not to be drowsy and stuporous during the day. If Inmate B accepted the medication, his struggle to maintain an adequate state of alertness during the day (his struggle to avoid descending back into stupor and delirium) would in fact have become even more arduous; he would have been forced to fight off medication-induced sleepiness as well as the torpor of monotony and enforced

idleness. He had complained to staff of this difficulty, but his complaints had fallen on deaf ears. During our subsequent interviews, other inmates confirmed this information.

In my professional opinion, it is appropriate to dispense sedating medication at night, not early in the day. It is critical to the inmates' mental health that they maintain some normal sleep-wake cycle, and - especially given the torpor induced by their environment - that they avoid the additional burden of being made drowsy by the medication they receive. Appropriate timing of medication dispensing might also go far to improving inmate compliance with medication .

Mental Health Involvement in Decisions Regarding SHU Housing.

Inmate B stated that he had spoken with Dr. Melendez about how much better he had done at CNYPC-Marcy, and had asked Dr. Melendez to help him be transferred out of SHU. Inmate B stated that he complained to Dr. Melendez that he could not take the stress of SHU, and that keeping him there was "setting me up for more tickets." He reported that Dr. Melendez ignored his complaint, and dismissed his request, stating that she has nothing to do with transfers.

Inmate B's medical record, and other inmate interviews, confirm this information that - in violation of the Eng agreement - Attica mental health staff still view themselves as passive bystanders in decisions regarding inmate placement and maintenance in SHU. Stipulation IA1, IB2, IC5-8.

In our January 25, 1999 conference at Attica, and despite explicit reference to the Eng Stipulation, both Executive Director Hal Smith and Dr. Melendez explicitly stated that they saw themselves as having no role in such matters. This is in direct violation of Clauses IA1, IB2 and IC5-8 of the Stipulation.

Private Interviews, "Psychotherapy"

Inmate B complained that there effectively is no meaningful opportunity for him to speak privately to a mental health staff member. He stated that his counselor, Bruce

Barten - referred to by the inmates by his first name - does make "rounds" several times a week, and acknowledged that Bruce seems to be reasonably well-meaning. But he complained that Bruce's "rounds" consist basically of passing by the cells a couple of times a week, perhaps stopping for a few minutes at a cell front to engage in casual conversation - all of which is heard by other inmates on the tier. Inmate B describes this as "having to shout your problems to everyone on the gallery." He insists that, despite his repeated requests, Bruce <u>never</u> takes him, or any other inmate, out of his cell for a "private interview" except for meetings with Dr. Melendez, and offers no explanation for his refusal to do so; "if you ask, it's no point."

Moreover, Inmate B states that Dr. Melendez is only very marginally available to him, and only speaks with him on rare occasions. Indeed, he complains that sometimes his medication is changed and no one even tells him about it: "You just see that it's switched." And when Dr. Melendez <u>does</u> see him, for a few minutes in the hearing room on the tier, Inmate B has no experience that these meetings are private: "They have a [loud]speaker in that [hearing] room. ... Everyone on the gallery could hear the conversation."[5]

Other inmates whom we interviewed corroborated Inmate B's claim that Bruce <u>never</u> takes an inmate out of his cell for a private interview except in order to bring the inmate to the hearing room to meet with Dr. Melendez. They also confirm that Dr. Melendez does not regularly herself participate in rounds on the tier; she sits with her charts in the hearing room while Bruce brings the inmates for her to interview. See Appendix F.

In our conversation with him during our site visit, Bruce entirely confirmed that these are, indeed, the current practices on the Attica SHU.

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5 As is indicated later in this report, several inmates raised this same concern about the hearing room.

Thus, despite the Eng agreement that SHU inmates would be able to receive appropriate mental health services, and despite the fact that SHU inmate treatment plans quite often centrally describe "Supportive Psychotherapy" as the proposed intervention, it appears that no meaningful opportunity for psychotherapy is yet provided. Stipulation IE.

Inmate B's case is especially striking in this regard. He had a history of prior psychiatric decompensations during periods of SHU confinement, and within a four month period of time, he twice psychiatrically decompensated in Attica SHU; on each occasion, he was massively ill and psychotically disorganized at the time of admission to CNYPC. On each occasion, he dramatically recompensated during hospitalization, and became cooperative, compliant, and actively involved in treatment. The behavioral disturbances which punctuated his course in SHU, disappeared in this setting. At CNYPC, he was encouraged to interact with other inmates and with his family. He engaged in group, occupational, and individual psychotherapy. He even was able to discuss very sensitive, painful and traumatic issues from his childhood in private psychotherapy. None of these treatments were available upon his return to Attica SHU. Indeed, the CNYPC Discharge Summary actually notes that SHU incarceration exacerbated Inmate B's psychiatric condition.

Moreover, the September 1998 CNYPC discharge summary makes explicit reference to Inmate B's need for continuing private individual psychotherapy: "His personal trauma is an issue that could be considered for inclusion in the treatment plan review process. Staff need be aware of the sensitive nature of these issues and that they would have to be discussed in an environment of privacy." Thus, in violation of the Eng Stipulation, ID1-2 and IE1-3, Inmate B was deprived of any meaningful continuity of care after his discharge from CNYPC and his return to Attica SHU.

One last point in regard to private interviews: Other inmates in addition to

Inmate B complained that they do not at all trust that the hearing room used by Dr. Melendez is truly a "private" setting; they complain that correctional staff listen in on the interviews and often afterwards make fun of an inmate on the tier for what he said in the hearing room. While I have no independent evidence whether this actually happens or not, it was clear to me from my inmate interviews that this was the <u>perception</u> of the inmates generally. (<u>See</u> e.g. Section III.6 below.)

2. Inmate C

Inmate C was the second inmate I interviewed. He, too, had a history of psychiatric difficulties prior to his transfer to Attica, and these vulnerabilities were also fairly characteristic of those seen among SHU inmates.

He had come from a disrupted home, and had lived in a group home during his childhood. He also had been psychiatrically hospitalized as a child for impulsivity, suicidality, and seizure disorder. His committing offense was apparently the consequence of a substance abuse disorder. Before arriving at Attica, he had a history of impulsivity, depression, paranoia, and suicidality; he had behavioral difficulties in prison, and had been sentenced to two years of SHU time just prior to his arrival at Attica in May 1998.

After he arrived at Attica, Inmate C began to refuse his medications - an antidepressant and an antipsychotic. Dr. Melendez responded to this information in a strikingly cursory manner - she stopped the medications, with no apparent attempt to understand the reason that Inmate C was refusing them. Indeed, in violation of the <u>Eng</u> Stipulation, Clauses IB5, IE1, and IF, there is no documentation of any adequate evaluation of Inmate C's past psychiatric, neurological and psychosocial history.

Such an evaluation would quite likely have been extremely useful. The medical record reveals that only a few days prior to his transfer to Attica, Inmate C had explicitly

stated why he was refusing antipsychotic medication; he believed that it could cause him to have a seizure. His belief was in fact entirely accurate; antipsychotics do lower the seizure threshold; they can cause a susceptible individual to have a seizure. If Dr. Melendez had inquired, she might have had the opportunity to discuss this issue with Inmate C, and form some basis for Inmate C to gain trust in her, and an understanding of the potential risks and benefits of her proposed treatment. The record does not reflect that any such discussion occurred.

In the months after June 1998, Inmate C was intermittently prescribed antidepressant medication and intermittently refused to take medications which were prescribed. The record reveals no attempt whatsoever at determining why he was refusing medications when he did so. For example, on November 19, 1998, Dr. Melendez noted that Inmate C had generally been refusing his medication during the prior weeks. Her note acknowledges that she had not seen him during the prior six weeks. She noted that she would discontinue his medication and inexplicably noted that he may not need continued mental health services.

During my interview with Inmate C, he complained of the disrespect with which he felt treated by the officers and staff. He stated that, without his permission, Dr. Melendez had ordered records to be sent to Attica from the Group Home where he had lived as a child, and that when he had protested this, she told him that she did not need his consent. Inmate C also complained that he never sees the counselor, Bruce, outside his cell except for meetings with Dr. Melendez, and that these tend to be quite brief - about 15 minutes total, including time for him to leave and to return to his cell. The record confirms this assertion: Logbook entries from June 1 through September 1998 indicate that Inmate C was interviewed once by Dr. Melendez on June 30, 1998; he left his cell at 2:23 p.m. and returned at 2:38 p.m. The SHU Reports from May through October 1998 indicate that no other interview was conducted.

3. Inmate D

This 34 year old black man has been at Attica since May 1997. He has a history of head injury leading to a seizure disorder, treated with the anticonvulsants, Dilantin and Depakote, a history of serious repeated, violent suicidal behavior (including slashing his throat with a razor blade), and of seriously disturbed behavior since childhood; he had been institutionalized as a child and psychiatrically hospitalized on several occasions prior to his incarceration at Attica. He had been diagnosed at CNYPC as having a psychotic mood disorder, and had been treated with antidepressants, anticonvulsant/mood-stabilizing medication, and antipsychotics.

In view of this history, Inmate D has received strikingly little mental health contact during his incarceration in Attica SHU. He was prescribed an anticonvulsant/ mood-stabilizer (Depakote) and there was a report in his mental health record on March 12, 1998 that the medication had helped him control his temper. Yet when, ten days later, Dr. Melendez noted that he had recently been refusing his medication, she discontinued the medication, with no apparent attempt to explore with him the reasons for his refusal; a few months later, without any substantial explanation, he was discharged entirely from mental health services.

During our interview with him, Inmate D described the reason he had become medication non-compliant; the medication he was prescribed had been making him groggy and this diminished alertness had left him "paranoid, hyper, on guard." He had known that the medication was supposed to help him sleep, but it was being dispensed, not at night, but shortly after noon. He had complained about this, but no one seemed to care, and Inmate D had developed a distrust of mental health staff at Attica. While he had generally positive feelings about the SHU counselor, Bruce - describing him as "a good guy" - he felt that Bruce did little besides passing by the cells briefly on his

"rounds." And he distrusted Dr. Melendez, whom he felt was unreasonable, not willing to listen, demanding, and controlling. During the period from March through October 1998, Dr. Melendez interviewed Inmate D only three times - during the weeks of March 9, May 25, and August 31.

4. Inmate E

Inmate E has received no mental health treatment since his incarceration in the Attica SHU in August, 1997, and there is no evidence that he has required any such treatment. He also was scheduled for release from prison in less than two months from the time of our site visit.

I reviewed his chart to help evaluate the implementation of those portions of the Eng Stipulation (IB2, IC3-4) which mandated that all inmates housed in SHU be psychiatrically screened on admission and their clinical status be at least briefly reviewed quarterly and regularly on rounds. His chart revealed substantial compliance with these portions of the Stipulation.

On interview, Inmate E noted that one of the counselors - Bruce or Steve - did come by and chat at his cell front every ninety days, and they seemed friendly and cordial. He also described, however, that some of his fellow SHU inmates seemed to be behaviorally in poor control, and as a result they "just keep getting tickets."

5. Inmate F

Inmate F has been housed in the Attica SHU since April 1993, and since then, has periodically displayed bizarre and disruptive behavior. His OMH records reveal a history of serious mental illness, including that he was psychiatrically hospitalized twice in the l980's. During the first years of his Attica SHU confinement - especially in 1993 and 1995 - he was described as suffering from both a psychotic disorder and from a

major depression.

He was evaluated by Dr. Melendez in January 1998, and the fact of his prior psychiatric hospitalizations was noted. However, Dr. Melendez' note reveals no inquiry into the nature or cause of these hospitalizations, nor does it even mention at all Inmate F's earlier disturbances during his Attica SHU confinement.

Based upon this inadequate informational foundation, Dr. Melendez' recommended medication (the sedating antidepressant Sinequan) and "supportive psychotherapy." Yet, the choice of medication - Sinequan - is questionable in light of the fact that it is a highly sedating drug which is normally prescribed for nighttime administration, and Inmate F would be required in the Attica SHU to take the medication just after lunch. Moreover, "supportive psychotherapy" was not provided other than Bruce's casual cell-front "rounds" - an activity which, although apparently well-intentioned, certainly would not constitute any meaningful psychotherapy.

There is virtually no other information contained in Inmate F's OMH record for 1998. The Attica SHU Reports indicate that he was interviewed once during the week of March 2, 1998, and there is one note from July which states that he was upset and crying. But the next month, Dr. Melendez stated only that: "He reports he is doing fine. ... He has faith in God." There was virtually no other attention paid to his psychiatric status. Yet by January 1999, the OMH record reveals the depth of his ongoing psychotic disturbance. He had become increasingly - obsessively, delusionally - preoccupied with the Bible, and he panicked and became tearful when he read something in the Bible which he thought might have some special significance for him.

During that month, Dr. Melendez finally noted that Inmate F's preoccupation was psychotic and that he seemed to have the delusional belief that he was the chosen one of God. Her response was to offer him Prozac - another antidepressant, without Sinequan's side effects. In violation of the Eng Stipulation (IA, IB, IC7) no proper

psychiatric evaluation was accomplished, and no consideration was given at all to the obvious possibility that Inmate F was psychiatrically deteriorating and might need to be removed from the SHU; indeed, no consideration was given to the fact that if Inmate F was seriously mentally ill, or had psychiatrically decompensated as a result of his SHU confinement, the Eng Stipulation required his removal from SHU.

In our January 1999 interview with him, Inmate F described his distrust of Dr. Melendez; he stated that the only reason he had spoken with her earlier that month was that she had threatened to put him in a strip cell if he refused to talk with her. He also began speaking - albeit obliquely - about his preoccupations with the Bible. He became visibly agitated and tearful as he did so, and his thought process became noticeably scattered and disorganized. He stated to us that he had tried to engage Bruce in conversation about the Bible at his cell front, but Bruce "just looks at me in disbelief."

6. Inmate G

Inmate G was sentenced to prison in May 1995, and has spent most of the period of his incarceration in SHU settings. He was transferred to the Attica SHU from the Elmira SHU in September 1996, and has remained in the Attica SHU since that time. Inmate G's medical record reveals a prior history of a serious psychiatric disorder - apparently a psychotic episode - during incarceration.

In June 1998, following a period of increasing agitation and disruptive behavior, he requested mental health services, stating that he was "depressed." According to the SHU logbook, he was interviewed by Dr. Melendez on June 30, 1998, but was back in his cell within 16 minutes. This cursory interview then was incorporated by Dr. Melendez into a psychiatric evaluation note; reference was made in this note to a presentence report, although the record does not state what, if any, specific information

was gleaned from that earlier report. The "evaluation" itself was quite cursory. It only went so far as to describe Inmate G as complaining of depression, but provided no information about the history or nature of this complaint, nor did it specify whether any signs or symptoms of depression were present. Moreover, the June 1998 evaluation stated that Inmate G had no history of prior mental health treatment, yet this assertion was plainly contradicted by the earlier sections of the psychiatric record.

Dr. Melendez largely dismissed Inmate G's complaint, stating that she would prescribe the antidepressant Sinequan, but opining - without any stated basis - that Inmate G "has mainly an antisocial attitude."

Without any additional contact with Inmate G, Dr. Melendez discontinued his medication in September 1998; she had heard that he was not accepting the medication, and without further inquiry she simply discontinued it. Her next actual contact with him was on October 8, when she saw him for the purpose of terminating him from mental health services.

During our interview, Inmate G expressed his distrust of the mental health services offered him at Attica SHU. He also expressed his belief that there was no privacy in the hearing room in which Dr. Melendez conducted her interviews - that it had a speaker in it and that the interviews conducted in that room were taped. He also claimed that the Corrections Officers sometimes played an inmate's interview tape on the tier as a means of harassing the inmate.

7. Inmate H

Inmate H is a 31 year old man who was transferred to Attica in August 1998, and has been housed in the SHU since that time. Inmate H came to Attica with a prior history of suicidal behavior documented in his OMH record. Shortly after arriving at Attica, he cut his wrist, and was described by the mental health counselor, Bruce, as

"crying, very emotional." He was placed on suicide watch in a B-North Observation cell; on interview there, he requested medication to help him control his temper.

Shortly afterwards, apparently without being evaluated by the psychiatrist, Inmate H was released from Observation on Bruce's recommendation, and was returned to his cell in SHU. There was apparently no further mental health service provided to him. Three months later, in December 1998 - without any actual interview with the inmate - Dr. Melendez discharged him from mental health services.

During our interview, Inmate H described the humiliation he experienced in B-North: "They put you there butt naked. You've got nothing to eat with. I broke off a piece of the Styrofoam to use as a utensil." He stated that he <u>had</u> asked to see "the doctor" for his mental health problems, but had never even been provided any opportunity to understand what mental health services he was supposed to have available to him. The only mental health service he actually received was a cell-front "evaluation" by Bruce - the mental health counselor. When I asked him about his interactions with Dr. Melendez, he responded with puzzlement; he had never met her: "I don't know who she is. ... I thought Bruce <u>was</u> the doctor."

IV. Compliance with the <u>Eng</u> Stipulation

This section of my report will focus on individual paragraphs of the <u>Eng</u> Stipulation and describe my findings for each specified clause. The clauses are referenced at the left hand margin in accordance with their paragraph designation in the Stipulation. I have not, in this first site visit report, attempted to precisely identify the percentage of cases or situations which did or did not comply with the particular clause of the Stipulation, but rather I have attempted to provide a more general statement - including my impression of whether there is evidence of effort being made to remedy

prior deficiencies.

This section concludes with a discussion of two issues - IV.9. Identification of Inmates for Whom SHU is Contraindicated and Provision of Alternative Placement, and IV.10. Failure to Adequately Review Prior OMH Records - which are interwoven through a number of clauses of the Stipulation. They are addressed in the context of the Stipulation as a whole to illustrate the critical cumulative effect of non-compliance with their purpose.

1. Screening On Admission to SHU (IB)

IB1. Timeliness-Initial screening conducted within one working day

My findings were generally that there has been substantial compliance with the timeliness element of this provision, and clear evidence of effort being made towards improvement in this regard.

IB1. Initial screening includes review of prior OMH records

My findings were generally of non-compliance here. The SHU screening notes which I reviewed often did not even cite the existence of prior OMH records, and more importantly, the substantive content of such records was never discussed. The Attica OMH staff identified only whether or not the inmate was on the active OMH caseload when they were transferred.

CNYPC's Policy and Procedure Manual explicitly describes the type of information which should be gleaned from the review of the prior OMH record and must be incorporated into the SHU Screening Note: "Description of the patient's previous experience in SHU and reaction as described by . . . OMH clinical record. . . . document medical, alcohol/drugs, mental health including a history of suicidal ideation or suicide attempts, and the patient's response to treatment: any history of emotional, physical, or sexual abuse. . . . Document the reasons for civil admissions (if any) specifying:

dangerousness to self or to others and any episodes of psychoses and agitation and describe the patient's history of hospitalizations at CNYPC (if any)." The Stipulation incorporates the requirements and standards of the CNYPC Manual at IF.

IB2 Initial screening is adequate to determine whether inmate is ill, at risk, or should be placed on active OMH caseload.

My findings are that there has been partial compliance with this provision. The very fact that SHU screening forms are actually being completed demonstrates some effort towards compliance, and the completion of such a form requires at a minimum that someone ask and consider important mental health questions. However, very often the informational basis upon which an inmate was deemed not to require active OMH involvement was grossly sketchy and entirely inadequate.

More importantly, no document at all - even those of recurrently, floridly ill inmates - revealed any consideration whatsoever of whether it was psychiatrically dangerous for the inmate to be housed in the SHU.

IB2 Another location

IB2 also includes an option to have an inmate who at assessment is identified as being "at substantial risk of serious mental or emotional deterioration if sent to SHU . . . promptly moved from SHU to . . . another location."

The Attica OMH staff are not in compliance with this provision. As is discussed in numerous sections of this report, even those inmates who have a history of mental illness and a history of prior mental deterioration in a SHU setting are not directed by OMH to be housed in another location despite the requirements of the Stipulation.

IB3 Active OMH patients placed in SHU assessments shall include a recommended plan for mental health treatment

My findings were of non-compliance with this provision. No individualized treatment plans are provided to SHU inmates identified as active OMH patients. Instead, all inmates appear to receive, in addition to medication, only one "plan" - which

is for “Individual supportive psychotherapy,” a form of treatment which is not even available or provided in the SHU.

Moreover, no records - even those of inmates with a history of psychiatric difficulty arising during prior SHU incarceration - revealed any treatment plan specifically addressing such difficulty.

IB4 Screening document includes assessment of prior SHU psychiatric problems.

My review demonstrated virtually total non-compliance with this critical provision of the Stipulation. Even in those - relatively few - cases where there was a notation in the assessment of the fact that an inmate had psychiatrically decompensated during a prior SHU confinement, never was “the basis of the conclusion” that the inmate “may be placed in SHU despite such a history” stated, nor were “steps that will be taken to monitor the inmate for a recurrence of such symptoms” described.

IB5 Assessment report sufficiently detailed to enable a clinically competent independent evaluator to determine whether it was conducted appropriately.

Virtually no record prepared by Attica OMH staff, came close to meeting the standard established in the Stipulation, that the documentation must be: “of sufficient detail to allow an independent evaluator to assess the accuracy of the determination.”

2. Periodic Monitoring of SHU Inmates

All of the following represent an effort to comply with the terms of the Eng Stipulation, and an improvement in services as compared with the situation before the Eng Stipulation.

IC1,2 Clinical presence for at least ten (10) hours per week to adequately monitor mental health status and needs of inmates.

The Attica SHU reports, logbooks and inmate interviews demonstrate that OMH staff are in compliance with the letter of these provisions. OMH staff regularly make rounds through the SHU, sign into the logbook and are reportedly in the SHU for ten or

more hours per week. This is an improvement over past practice.

However, these provisions require that the monitoring be “adequate” to determine the “mental health status and needs of the inmates confined” in SHU. As indicated in reference to other more specific provisions of the Stipulation and in the section of this report concerning specific inmate OMH files, the monitoring is not yet adequate. “Adequacy” cannot be measured simply by a statistic of man-hours-per-week, but must also be measured by actual services accomplished. The clinical services - assessments, psychotherapy, pharmacologic management - which are provided in the Attica SHU are inadequate.

IC3 Rounds shall include: a) discussion with DOCS staff; b) review of logbook entries; c) a reasonable opportunity for inmates to communicate.

The SHU logbooks appear to be reviewed by OMH staff regularly and in our discussions with OMH staff they reported that they meet regularly with OMH staff to review inmate behaviors. Inmates generally reported that mental health counselors made rounds and could be engaged in minor conversation.

However, as is indicated below in reference to IC4 and elsewhere in this report, requests to communicate other than briefly at cell side were almost never granted nor is it apparent that the opportunity to do so is available to SHU inmates.

IC4,5 Identify inmates who: a) exhibit mental deterioration or appear at risk of self harm; b) request services; c) wish to communicate with OMH staff; d) are unaware or unresponsive; and, record the relevant information in a screening or progress note in the inmate’s OMH record.

As stated above, there has been very substantial improvement in regard to regular rounding on SHU inmates, and clearly at times such rounding results in further clinical intervention. At the same time, however, our inmate interviews and record reviews raise a substantial question as to whether there is a practice of consistent documentation of the information gleaned from such rounds, as required by the Stipulation. There were, for example, inmates who reported to us that, during rounds,

they had asked for a private mental health interview, and this request had been refused, yet the inmate chart revealed neither that the request was made, nor the justification for refusing the request.

IC6 SHU inmate exhibits symptoms or behavior that indicate mental deterioration or substantial risk of self harm - a further OMH mental health assessment shall be conducted within one working day.

Similar to the initial assessments conducted upon transfer to SHU, there appears to be substantial compliance with the timeliness element of this provision. This represents a substantial and important improvement in clinical services in the Attica SHU.

IC7,8,9 These three provisions mirror the requirements of Stipulation sections IB2,3,4,5 concerning the conduct and record of the re-assessment process. Inmates that have developed a severe mental disorder or an exacerbation of preexisting mental disorder, are at risk of mental deterioration in SHU shall be moved. Screening document include basis of clinical conclusion that inmate may be returned to SHU. Treatment plan shall address prior deterioration in SHU. Assessment report will be sufficiently detailed to enable a clinically competent independent evaluator to determine whether it was conducted appropriately.

As described above in reference to sections IB2,3,4,5, the re-assessments suffer from inadequacy and lack of compliance with the provisions of the Stipulation: OMH staff do not recommend that inmates be housed in a location other than the SHU despite knowledge of prior and oft repeated mental deterioration of the mentally ill inmate when housed in SHU; OMH does not create a recommended plan for mental health treatment which addresses the prior deterioration in SHU for those inmates approved for return to SHU; documentation prepared by OMH does not reflect changes in the treatment plan to be made due to the inmate's inability to function in the SHU environment; and the entries in the OMH records are not sufficiently detailed to enable a clinically competent evaluator to assess the adequacy of the interaction.

3. Private Interviews

The Attica SHU reports and the SHU logbooks provide documentation of the few private interviews that have been conducted during the first period of the Stipulation. Information from these documents has been compiled and is attached in several appendices: information from the SHU reports (Appendix C); the 2nd Rec. Logbook (Appendix D); the 3rd Rec. Logbook (Appendix E); and, both logbooks combined (Appendix F). Each of these appendices was prepared at my direction by plaintiffs' counsel, Sarah Kerr. These records reflect that very few private interviews were conducted with SHU inmates by OMH staff and that this was true even for those inmates who were active OMH patients at the time.

ID1-4 Private interviews will be provided when requested by OMH staff or (not to exceed once/week) by inmate except where: OMH staff determines private interview not indicated and so documents, or DOCS staff determines there are countervailing security issues which DOCS documents in the SHU log and which OMH documents in the OMH record.

During my interviews, several inmates reported that they had been refused private interviews. No justification for the refusal was verbally communicated to the inmate, and no documentation whatsoever appears in the record. Inmate records which include "supportive psychotherapy" in the treatment plan do not reflect requests for or the completion of private interviews.

ID5 All SHU inmates continuously confined in SHU who are active patients of OMH or are subject to a screening note or who are determined to be at substantial risk by OMH shall, unless the inmate refuses, be privately interviewed by an OMH professional at least once every three (3) months.

A procedure appears to have developed for Dr. Melendez and a mental health counselor to periodically meet together in the hearing room outside the tier with each active OMH inmate, and it appears that if the inmate is willing, such interviews occur at least quarterly. This represents a substantial improvement in services.

However, there remain very substantial deficiencies in this regard: such interviews are generally quite perfunctory - apparently less than fifteen minutes in most

cases. Moreover, they occur in a hearing room on the tier which most of the inmates interviewed believed entirely lacks privacy from the correction officers; indeed, several inmates claimed that there is a microphone in the room and that what they have said during the interview has been repeated over the loudspeaker on the tier. Although I have no basis for determining whether or not this perception is based upon any actual occurrences, clearly - since this room is the same room that is used for disciplinary hearings - it is not a location likely to create an atmosphere of trust.

In addition, this procedure virtually completely bypasses those mentally ill Attica SHU inmates who are too fearful or paranoid to leave their cells. Instead of particular attention being paid to such inmates, virtually no attention is paid to them at all until they become "unable to function" in SHU.

4. Continuity of Treatment

IE1 Active caseload inmate treatment plan to continue upon transfer to SHU unless and until modified according to IE3; for inmates added to OMH caseload initial treatment plans to be created in accordance with CNYPC Outpatient Record Manual.

IE2 Inmates placed in SHU following a stay at CNYPC shall have the CNYPC Discharge Summary implemented unless modified according to IE3 or are modified by OMH mental health professional based on a consideration of the treatment goals and potential effects of the SHU environment.

IE3 Whenever active OMH patient transferred to SHU,a treatment plan review will be performed within ten (10) days. The plan will be consistent with DOCS security requirements and will meet the standards in the CNYPC Outpatient Record Manual.

From my inmate and staff interviews and from my review of records, I have observed evidence of effort to improve documentation of treatment planning, but there is clear evidence that there has been little movement towards substantive improvement in the treatment provided in the Attica SHU. The documentation has improved - although in my opinion it is still not close to compliance - and there is evidence of some compassionate, respectful interaction between mental health workers on the SHU and

inmates, but virtually no actual treatment is being provided on the Attica SHU.

Treatment plans for active OMH SHU patients almost invariably call for "individual supportive psychotherapy," but no such psychotherapy is actually provided - only cell-side cordialities and encouragement. From my interviews with inmates, it appears that these interactions are typically seen as well-meaning, but they are brief, cursory, and entirely public; none of the inmates interviewed would consider revealing sensitive information during such an interaction.

Moreover, psychopharmacologic management generally occurs in a vacuum. From my interviews with inmates, it is clear that most do not understand why particular medications are being prescribed; often they do not even know what medication they are being prescribed, or why it was suddenly changed. They do not understand the potential benefits nor the potential side effects of such medication, and virtually no prisoner interviewed felt he had any trusting relationship with the prescribing psychiatrist. Non-compliance with prescribed medication is, therefore, exceedingly common. Thus, neither of the two modalities of treatment which are generally included in Attica SHU OMH treatment plans - medication management and supportive psychotherapy - are meaningfully provided.

The CNYPC Policy and Procedures Manual requires a consultation and team conference - "Patient Care Monitoring" (PCM) - for any inmate hospitalized at CNYPC who had been housed in a SHU setting just prior to his hospitalization. This conference is intended to address the question of whether there is a psychiatric contraindication to the inmate's being returned to a SHU setting after discharge and, in those cases where it is concluded that the inmate can return to SHU, what alterations in his treatment need to be effected in order to prevent a recurrence of the difficulties which led to the hospitalization.

These PCM's, which should be included in the OMH record for each SHU inmate

after a hospitalization at CNYPC, are accomplished only sporadically and in practice they have little substance. Many of the OMH records of inmates that had been transferred from CNYPC back to the SHU did not contain any PCM review. The PCM's that I did review never incorporated an instruction that the patient could not tolerate a return to SHU.

At the conference during the first site tour, I requested a copy of the current OMH policies and procedures that are used to determine whether it is appropriate to send an inmate back to the SHU. I also requested information about what documents are reviewed at the time of the decision. Hal Smith, Executive Director CNYPC, indicated that there are no written criteria or policies and procedures. However, he offered to provide a memo and letter from Dr. Buscema, Acting Clinical Director of CNYPC explaining the process. The January 7, 1999 memo by Charles Buscema, M.D., Acting Clinical Director of CNYPC, that was provided in response to this request does not explain the manner in which PCM's are conducted. The title of the memorandum suggests that the inevitability of the return to SHU is actually OMH policy: "PCM's on Patients Discharged from CNYPC & Returning to a SHU Environment." The content of the memorandum indicates that Dr. Buscema realized in January 1999 that in fact "patients who are returning to SHU environments upon discharge from CNYPC are still not receiving combined inpatient/outpatient PCM's as part of the process of 'seamless transition.'"

Finally, much of the core of psychotherapeutic rehabilitation - group interaction, recreational and occupational therapy, increased opportunity for family visitation and other interaction - is simply not available in SHU as it is presently operated. The inpatient program at CNYPC is replete with such therapies, and even the RCTP program at Attica emphasizes such treatments. Yet absolutely none of them is made available to SHU inmates no matter what the PCM or treatment plan requires. Given

that there is no individualized treatment offered in the Attica SHU - no private counseling sessions, no group, occupational or recreational therapy, and no educational or other rehabilitative services - it necessarily follows that the PCM process has no real treatment recommendations to make. In practice all the PCM process can do is to endorse whatever recommendations have been made by the CNYPC clinical staff for medication changes; the PCM process thus becomes entirely irrelevant and redundant - a pointless exercise.

None of the OMH records, nor any of the other documents I reviewed (such as Quality Assurance Reports) reveal any consideration or concern about this core problem in the provision of adequate mental health services in Attica SHU.

5. Patient Records

IF OMH patient records for all SHU inmates shall be maintained in accordance with the CNYPC Outpatient Medical Record Manual.

In my record review, I did not find that the Attica OMH staff were in compliance with this requirement. Some of the records reviewed, however, did include reference to some other evaluation prepared elsewhere; most commonly, this was an inpatient document from a CNYPC hospitalization (such as a discharge summary). These latter documents were generally detailed and reasonably comprehensive, and in themselves, might well comply with the adequacy criteria above. However, in no case did an Attica OMH record adequately reflect information that was required by provisions of the Eng Stipulation.

Attica SHU psychiatric evaluations which did not properly refer to the prior documentation of mental illness were uniformly devoid of sufficient psychiatric information to form the basis for an adequate assessment of an inmate's past psychiatric and psychosocial history or his current treatment needs.

Despite this negative conclusion, however, it should also be stated that there is

clear evidence of increased effort here and of some movement towards compliance. There is more in the charts than in the years prior to the Eng Stipulation, but it is still inadequate.

6. Quality Assurance

IG1 CNYPC will ensure all mental health professionals conducting assessments described in the Stipulation shall be aware of the standard of review and steps required for adequate assessment and the steps that must be taken if SHU is contraindicated.

IG2 CNYPC will ensure all OMH staff responsible for monitoring or other contacts with SHU inmates shall be aware of the standards and steps necessary to adequately determine an inmate at risk, in need of intervention and steps to be taken in response.

IG3. CNYPC shall periodically review SHU assessments and OMH monitoring activity to ensure they are accomplished professionally and in accordance with Stipulation. Review information to be maintained at CNYPC. Adverse findings shall be reviewed with OMH staff and a plan of corrective action taken.

IG4 CNYPC shall promptly review the decision to transfer to SHU any inmate who previously deteriorated psychiatrically in any SHU unit, in order to assess the appropriateness of such decision, the adequacy of the documentation, and to ensure the decision is consistent with the terms of this Stipulation.

As documented throughout this report, there has been a widespread failure of compliance by OMH staff with important requirements of the Stipulation. OMH staff do not make adequate assessments and the response to at risk inmates is very limited (e.g. OMH rarely if ever intervenes to have an identified at risk inmate housed in a location other than SHU, psychiatric treatment plans which require supportive psychotherapy are simply not followed in any substantively meaningful manner, and treatment plans do not reflect the necessary concern about monitoring for deterioration).

All OMH quality assurance documents from the date of the Stipulation March 6, 1998 through October 27, 1998, were requested in the document request for this first site visit, which was dated October 27, 1999. After the site visit we received 3 one

paged sheets prepared by Mr. Karker and 18 one paged sheets prepared by either Dr. Chaudhri or Dr. Faruki at CNYPC. In addition we received the minutes from the March Quality Assurance - Eng meeting notes.

The three documents prepared by Mr. Karker each indicate a review of 6 Eng Stipulation requirements for a specified one month period: 1) assessment completed within one working day; 2) review of OMH records to determine current OMH status and OMH history; 3) 10 hours per week clinical presence in SHU; 4) OMH review of DOCS SHU logs; 5) movement of SHU inmates to OMH within 48 hours of being determined to require immediate treatment/evaluation in a mental health setting or to be at substantial risk of serious mental or emotional deterioration if maintained in SHU; 6) access to private interviews: Not to exceed once a week for SHU inmates who request such interviews and, at least once every three months for active OMH patients, inmates subject to a screening note or inmates determined by OMH to be at substantial risk. One form was completed on November 12, 1998, one on December 23, 1998 and the third was completed on January 12, 1999. No similar documents were provided to cover the first eight months of the Stipulation and these three reviews were not completed until after we requested documents in preparation of this first tour. It appears from the documents that nothing was done to comply until we asked for the documents.

Each of these three forms indicate in the column "Corrective Action" that the lack of private interviews needs to be addressed. The form dated January 12, 1999 indicates that a meeting was held on January 6, 1999, a monitoring form was generated, and someone met with the Superintendent to discuss a plan to get inmates out of cells for interviews.

The eighteen documents prepared by Dr. Chaudhri or Dr. Faruki purport to each review one inmate record to monitor 4 Eng Stipulation requirements which are listed on

the form as: 1) Screening on admission to SHU: Documentation of determination that inmate has a severe mental disorder or severe depression and is currently exhibiting symptoms which requires immediate treatment/evaluation in MH setting; 2) Screening on Admission to SHU: Documentation of determination that inmate who is an active patient does not require removal from SHU. The assessment is to include a recommended plan of MH treatment while in SHU; 3) Screening on Admission to SHU: documentation of the fact that an inmate has previously developed a severe mental disorder, suffered an acute exacerbation of a preexisting mental disorder or otherwise substantially deteriorated while in any SHU. If Inmate may be placed in SHU despite such a history, assessment is to include the basis for that decision and the steps that will be taken to monitor the inmate for a recurrence while he is in SHU; 4) Periodic Monitoring of SHU Inmates: When the decision is made that an inmate removed from SHU for treatment and evaluation may be returned to SHU the documentation shall address any changes in the treatment plan which reflect the issues which contributed to an inability to function in a SHU environment, a consideration of possible warning signs of deterioration and a plan for monitoring such signs.

All of the eighteen forms were completed during the three business days prior to our site visit. They each indicate an ending date for the relevant monitoring period of December 23, 1998 and have left blank the area for the starting date of the monitoring period. Again, it appears that nothing was done to comply until we requested documents. It is doubtful that <u>any</u> of these reviews are compliant with the IG4 requirement of a "prompt review." This is a serious area of non-compliance. The failure to make a prompt review in compliance with IG4 may result in the inappropriate placement in SHU of an inmate who is known not to be able to tolerate a SHU environment. Because the forms that were provided do not indicate the name or the inmate number for the inmate whose chart was reviewed I am unable to address

specific failures in the quality assurance review that may have occurred - I do not have the information to know which inmate and which transfer gave rise to the review in the documentation.

Although it is not clear whether or not one of these forms is filled out for each inmate admitted to the SHU (or only for active OMH or prior OMH patients admitted to the SHU) it is clear that many more than 18 of these forms should have been completed between March 6, 1998 and October 27, 1998. Logically there should be a form filled out for each and every inmate admitted to the SHU. Otherwise, CNYPC would not be able to review whether or not the assessment included a complete review of the OMH records and accurately identified an inmate not on the active OMH list but who has had prior OMH history including prior psychiatric deterioration in a SHU setting. DOCS counsel represented that these forms are supposed to be prepared for all inmates who have been returned to SHU from an OMH setting - either CNYPC or the Attica Satellite Unit. Regardless, during the time period covered by the document request there were more than eighteen occasions that resulted in one of the following: the admission of a SHU inmate with a prior OMH involvement to the Unit; an inmate admitted to the SHU from the Satellite Unit at Attica; or an inmate admitted to the SHU from CNYPC. (Inmate records, logbook entries, and other documentation reflect more than 18 occasions.)

In all of the 18 forms that were produced, Dr. Chaudhri and Dr. Faruki found proper documentation and determination of whether the inmate has a severe mental disorder or severe depression and is currently exhibiting symptoms which requires immediate treatment/evaluation in MH setting and proper documentation and determination of whether the inmate who is an active patient does not require removal from SHU - assessment to include a recommended plan of MH treatment while in SHU. (One form did contain a note that an earlier assessment by the psychiatrist would have

been more useful.) Since I, on the other hand, found virtually no adequate effort in any of the charts which I reviewed, I find this discrepancy puzzling.

In four of the eighteen reviews, Dr. Chaudhri did find cases where inmates who previously suffered deterioration in a SHU setting, were returned to SHU without the record reflecting an adequate justification for the placement in SHU and/or without any monitoring plan in the record as is required so that signs of deterioration are detected. However, in each case, Dr. Chaudhri's recommendation solely indicated the need to better document the decision that was already made. At no point does Dr. Chaudhri express or raise an alarm about the possibility that decisions based on these inadequate records are simply wrong. His recommendations never include consideration of the possibility that a case may represent one of unrecognized clinical danger - that perhaps this inmate really should not have been placed in the SHU.

Other than these two forms - the one filled out by Mr. Karker and the one filled out by Drs. Chaudhri and Faruki - no other quality assurance documents have been provided. These two forms simply do not cover all of the Stipulation's provisions that are supposed to be subject to a quality assurance review by CNYPC (e.g. conformity of OMH record entries with the CNYPC Manuals, Stipulation IE1, IE3, IF; implementation of the CNYPC discharge treatment plans, Stipulation IE2).

IG5 CNYPC maintains JCAHO Certification and provides relevant documentation to plaintiffs.

OMH senior staff are justifiably proud of the Three Year Accreditation their services have received from JCAHO. However, the JCAHO process is not designed to address the special mental health issues in a correctional setting, and specifically declines to review decisions justified by "security" considerations.

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"; it will, on the other hand, be willing to review the use of these cells for General Population inmates, in circumstances when the justification for their use is "clinical."

Furthermore, JCAHO commends CNYPC's Satellite Units for their attention to the needs of inmates for education and for personal dignity. For example, they specifically commended CNYPC for the fact that 80% of the Satellite Unit inmates' learning needs, abilities and readiness were properly addressed, and for the fact that 80% of resident sleeping rooms had hanging pictures and/or pressboards in order to display personal mementos. Clearly, JCAHO recognizes that such amenities are important in psychiatric treatment, but does not see itself as in a position to comment upon the absence of such amenities for SHU inmates.

JCAHO finds CNYPC in compliance on many other features of good psychiatric care - family involvement, academic education, and so forth - these too have absolutely no relevance to the SHU inmate. The process simply does not examine the treatment issues raised by SHU confinement.

7. Notification and Training of Staff

IH1-2 DOCS staff regularly assigned to SHU and all OMH staff having contact with SHU shall be informed of the requirements of the Stipulation, and shall be required to participate in training to recognize and respond appropriately to the psychological needs of SHU inmates.

I have reviewed the syllabus of the July 1998 training seminar for DOCS staff, a joint effort of OMH and DOCS, and generally found it impressive, and in substantial

compliance with the requirements of the Stipulation. I would, however, suggest that some education be provided regarding disorders very commonly seen among SHU inmates, which are associated with heightened psychiatric risk. These include Attention Deficit Hyperactivity Disorder, and the various forms of Impulse Control and Atypical and Organic Mood and Affective Disorders. Moreover, the syllabus should be aimed to increase awareness of the importance of observations of changes in the inmate's daily functioning and behavior - for example, his sleeping and eating habits, how much time he spends exercising or reading, as opposed to just lying in his bunk, a change in his hygiene, or in his willingness to talk with staff and so forth.

I have no information whether any procedure has been established to ensure periodic updating and retraining, nor whether there is a procedure to ensure that new DOCS and OMH SHU staff are provided such training. Such procedures are, of course, required for compliance with the Stipulation.

Moreover, I have no information as to whether DOCS personnel have been provided a copy of the Stipulation and been given specific information regarding the requirements therein.

8. Deprivation of Items

II1,2 Deprivation of Items in the MHU.

I have no information regarding the policies and procedures now in force regarding clothing, mattresses, blankets and toilet paper for SHU inmates housed in Mental Observation cells. I hope to explore this issue during our next site visit.

I am aware, however, that several inmates complained during my interview with them that they had been kept in Mental Observation for prolonged periods of time with none of these amenities.

9. Identification of Inmates for Whom SHU is Contraindicated and Provision of

Alternate Placement

Removal of Inmates from SHU and identification of inmates contra-indicated for SHU

Numerous provisions of the Stipulation require that OMH identify inmates who are contra-indicated for SHU placement based on their prior history or based on their deterioration while in SHU (e.g. IA1, 1B, 1C6-7). There appears, in practice and in expressed policy, to be no attempt whatsoever to come into compliance with these critical provisions of the Eng Stipulation. In practice, as illustrated in the Inmate Profiles described earlier in this report, mentally ill inmates are transferred from SHU only when the inmate is floridly agitated or otherwise at immediate risk to himself or others. Then, after this dramatic symptomatology abates - after either a few days in the Satellite Unit mental observation cell, or a more extended period of hospitalization at CNYPC - the inmate, often in an extremely precarious psychological state, is returned to Attica SHU to continue his term of punishment.

[redacted section]

Stipulation provision IA1 is simply not this limited. IA1 states: "in no case shall an inmate known to be currently suffering from a severe mental disorder or severe depression and who is currently exhibiting symptomatology which requires immediate treatment/evaluation in a mental health setting or who is known to be at substantial risk of serious mental or emotional deterioration, be placed or maintained in SHU." At no point in the Stipulation is "symptomatology" or "risk of deterioration" limited to "imminent danger to self or others."

[redacted section]

OMH staff have set the hurdle exceptionally high: only when such overt deterioration results in an "inability to function" in SHU, must transfer be considered. Inability to function is in turn defined as deterioration to the point of "imminent danger to self or others" or extreme psychotic symptomatology. Consequently extremely mentally

ill inmates continue to be trapped in the revolving door of SHU-to-mental health setting-to SHU with OMH failing ever to intervene as the Stipulation requires.

The inexcusable paradox that exists, due to the manner that the Stipulation is being implemented and the manner that Attica OMH staff view inmates in their care, is that the very behaviors that evidence mental deterioration (e.g. refusing medications, attempts to lacerate or hang oneself, refusing to leave one's cell for any purpose, smearing and throwing feces) are the behaviors that are interpreted as "manipulating" in order to get out of SHU and, therefore, result in OMH's refusal to transfer the inmate. There is no way to meet the standard - no way to escape the revolving door.

The inmate profiles detailed earlier in this report illustrate that tragically this practice is precisely what is currently in place. In addition, as part of the site visit, I reviewed copies of the Attica Weekly SHU Clinical Review Meetings. These meetings included Scott Clair, Bruce Barten, and Dr. Melendez. The minutes of these meetings cite many examples of obviously psychotic symptomatology and bizarre behavior among SHU inmates, and no felt need by these OMH staff to intervene. They also contain examples of extremely glib choices to interpret bizarre behavior as "just manipulating." For example: "Seeks staff attention by asking questions about a variety of topics, such as 'the brain'"; "Acting out behaviors persist. Smearing feces on floor in order to disturb neighboring inmates."; "His bizarre behavior continues, but is baseline for him."; "does experience religious delusions but is in no distress."

These weekly meetings are extremely brief - generally about twenty minutes in length. There is no documentation of any in depth discussion of any ill SHU inmate. And never, in any of these meetings, or in any document provided to us by Attica OMH staff, is there any discussion of the possibility that any inmate is simply too chronically fragile to be capable of tolerating SHU confinement. The meeting documents an unacceptable willingness to retain severely ill, psychiatrically deteriorating inmates in

SHU. Indeed, only when such overt deterioration results in an "inability to function" in SHU, must transfer be considered.

10. Failure to Adequately Review OMH Records

Review of prior OMH records

Many clauses of the Stipulation require OMH staff to review and utilize information available in the inmate's prior OMH and other psychiatric records. This activity is critical in the formulation of any competent psychiatric evaluation and treatment plan, and the Stipulation incorporates the importance of such activity throughout its provisions. (See Appendix G for a summary of all of the references to prior OMH records.) However, despite the evident importance of reviewing prior records, Attica OMH staff often failed even to cite the existence of such prior records, or the fact that they had been reviewed. Moreover, even when the Attica OMH staff stated that such records had been reviewed, the substantive content of such records was almost never described, and virtually never was any actual information from such prior records incorporated in the Attica psychiatric evaluation and treatment plan documents.

The net effect of non-compliance with these requirements is that Attica SHU OMH staff fail to utilize the information in the inmates' prior psychiatric records in a manner consistent with any reasonable standard of clinical practice - including the standards stated in CNYPC's own Policy and Procedure Manual. The records I reviewed reflect this non-compliance. The evaluation of an inmate's present situation is unacceptably ahistorical. Each moment of observation becomes an event unto itself - devoid of any attempt at meaningful integration of past events and observations with present observations. This *modus operandi* irretrievably compromises assessment and diagnosis.

This failure of historical synthesis allows the Attica SHU OMH staff to glibly

describe an individual as, today, “Not mentally ill,” even though yesterday - and recurrently - he was manifestly and quite dramatically ill. This non-compliance also results in the staff to over diagnosing “malingering” and “only manipulating”; rather than making an actual valid clinical assessment of the inmate.

V. Summary and Conclusions

Although this site visit did reveal evidence of some efforts to improve procedurally the psychiatric services available on the Attica SHU from the situation prevailing prior to the Eng litigation, I unfortunately must conclude that no substantively meaningful improvement has yet taken place.

As stated earlier in this report, the Eng Stipulation was constructed to address serious and potentially fatal deficiencies in the management of severe psychiatric illness found among inmates in the Attica SHU, and in the staff’s unconscionable attitude of scorn and indifference in the face of the massive psychiatric deterioration occurring among Attica SHU inmates under their care. Those deficiencies fell into two broad categories:

1. **Case-Finding - Evaluation & Monitoring:** Inmates admitted to SHU were not screened psychiatrically, and their psychiatric status was not periodically monitored. Inmates with previously documented psychiatric illness did not receive adequate evaluation at the time of SHU admission, nor - despite the fact that SHU is by intent designed to be psychologically punishing - did those evaluations address the inmate’s potential vulnerability to psychiatric decompensation during such punitive SHU confinement. Moreover, given the inadequate or non-existent psychiatric monitoring of SHU inmates, inmates who developed psychiatric illness during such confinement, or for whom such

confinement caused an exacerbation of previously existing psychiatric illness, were not identified or meaningfully evaluated.

2. **Response to Identified Psychiatric Difficulties - Alternate Housing & Treatment in SHU:** there was a shocking indifference to the serious psychiatric illness observed among Attica SHU inmates. Virtually no meaningful treatment was offered. There was an attitude of “punishment at all costs” - even at the cost of death itself. Those who could not tolerate punitive SHU confinement would only be relieved from it when their “inability to function in SHU” had become grotesquely apparent, and even then, the relief would be unconscionably brief; they would be patched up just enough so that they could be once again returned to an environment which they manifestly were unable to tolerate.

Unfortunately, despite some pockets of improvement, these deficiencies essentially continue to be present, without any substantively meaningful change. I do hope, however, that the comments which follow will not be perceived as a condemnation of the individuals employed at the Attica SHU. During my site visit, I felt from some senior officials - including Hal Smith, Bruce Bradigan, and Scott Clair - a genuine desire to accomplish and to improve conditions. Moreover, my interviews with inmates also revealed that Bruce Barten - the OMH staff member most visible on the SHU - is generally thought of as kind and well-meaning; fewer inmates have contact with Scott Clair, but those who knew of him also had generally positive feelings towards him.

These conclusions, then, are not about individuals. They are about a system which, in my view, has not yet demonstrated the will to change:

1. **Case-Finding**

Evaluation

The psychiatric evaluation of Attica SHU inmates are in general grossly inadequate. They often are little more than glib "impressions" of a diagnosis - almost entirely of the moment, without any meaningful attempt to integrate the past psychiatric and psychosocial history into the assessment of current behavior. They are in general grossly below the standards created by CNYPC itself, in its Policy and Procedure Manual.

Moreover, their very inadequacy - their momentary, ahistorical, basis - allows staff members to repeatedly diagnose psychotic behavior as something less (e.g. "malingering," "manipulating," "pursuing his own agenda to get out of SHU"). There continues to be a predilection to view inmate behavior as "manipulative" and hence of no cause for serious concern. This characterization, often made without any meaningful effort at evaluation and differential diagnosis, often results in staff dismissing and ignoring symptoms of severe mental illness.

At the same time, I wish to note that there have been some improvements here. The quality of the evaluations is better than it was in the 1980"s. Moreover, prior to Eng, Attica SHU inmates who were not on the active OMH caseload generally received no psychiatric evaluation at all; this has clearly changed for the better.

Periodic Monitoring

In many respects, this is the area of most noticeable improvement. Rounds are being done regularly. There are procedures in place for periodic review of all SHU inmates - even those not on the active OMH caseload. OMH staff does seem to review DOCS staff's observations and logbook recordings. All of this represents a very substantial, and very welcome, improvement in the quality of services provided.

At the same time, there remain serious deficiencies in the use of these observations by OMH staff. The observation of disturbed behavior often actually yields

nothing; the disturbed behavior continues to be observed day after day, but then simply ignored; there is no adequate response to the observation.

2. **Response to Identified Problems**

Psychiatric Treatment for Attica SHU Inmates

The psychiatric treatment available to Attica SHU inmates remains grossly inadequate - indeed, in many respects, non-existent. In the SHU itself, there is no opportunity whatsoever for private, individual psychotherapy, let alone any other form of expressive therapy, or group, occupational, or recreational therapy. The only "therapy" provided is brief, cell-side chats with the unit counselor, conducted as part of his "rounds" on the SHU. This is the case even when a discharge summary from a CNYPC hospitalization specifically recommends the need for privacy in continuing psychotherapy. Medications are offered, but there is no meaningful opportunity for inmates to develop a trusting relationship with the unit psychiatrist, and little or no meaningful effort to engage them in such a relationship; thus, inevitably, medication non-compliance by inmates is rampant.

When an Attica SHU inmate becomes clearly incapable of tolerating SHU, the only alternative offered at Attica is - generally very brief - confinement in an isolated Mental Observation cell in the Psychiatric Satellite Unit. Such confinement, however, does not provide any amelioration of the inmate's conditions; indeed, in many ways it involves more deprivation than exists in the Attica SHU cells - including deprivation of clothing, bedding, or any personal effects or reading material.

Alternate Housing for those Inmates Incapable of Tolerating SHU

Inmates who are deemed to be incapable of remaining at Attica are sometimes psychiatrically committed to CNYPC. Very ill inmates often recompensate dramatically during such hospitalization; this clearly must be a tribute to the clinical work being done

at the hospital.

However, in practice - and in the expressed view of Hal Smith, Director of OMH Forensic Services - CNYPC does not view itself as having the responsibility for long-term care of behaviorally disruptive, psychiatrically ill inmates. Thus, once an Attica SHU inmate sufficiently recompensates at CNYPC, he is routinely returned to Attica, where he is inevitably returned to the SHU.

The result is a “revolving door” pattern of psychiatric deterioration in SHU, leading to transfer to CNYPC, only to once again result in another round of SHU confinement and decompensation. This pattern remains as prevalent today as it was at the time of the initial preliminary injunction in the Eng lawsuit. It is a pattern of conduct which directly violates one of the most central foundations of the Eng Stipulation.

Moreover, the Eng Stipulation called for review of any inmate who had been committed to CNYPC from the Attica SHU upon their return to Attica. Stipulation IE. This review would consider both the appropriateness of the inmate’s returning to SHU and - for those evaluated as capable of doing so - would describe adjustments in planning to prevent recurrence of the difficulties which had resulted in hospitalization.

These reviews (the Patient Care Monitoring - “PCM” reviews) are not being done consistently. More critically, as demonstrated in the body of this report, these PCM’s have proven virtually worthless. The actual intent of the reviews has explicitly not been to consider whether a prior SHU inmate should be returned to SHU, but rather only to review such inmates before they do return. There is simply no expectation whatsoever that the result of the review will be a recommendation for no return. It never happens, and there is no apparent intent of it happening.

Thus, the only alternative might be for the PCM to recommend changes in the treatment plan in Attica SHU to prevent a recurrence. But since there is no treatment offered at Attica SHU except medication and cell-side chats, the PCM review in reality

consists of nothing more than the endorsing of whatever medication recommendations were already made by the CNYPC clinician. Given these realities, the PCM process becomes a sham - a pointless exercise.

Recommendations

There are a number of very concrete steps which could be taken to address issues raised in this report. By implication, the report itself suggests these steps. However, in this First Report, I think it less important to provide a lengthy list of recommendations, than it is to suggest that there is one central, pivotal issue, an issue which, in my opinion, drives many of the other observed deficiencies and systemic failures: No long-term treatment and housing options have been developed for the recurrently ill, recurrently behaviorally disruptive, Attica SHU inmate.

As a result of this reality, the “revolving door” of decompensation in SHU leading to brief respite and then return to the toxic SHU environment, continues basically unabated. Mentally ill inmates continue to be housed in SHU even after they have recurrently become floridly ill and out of control in that setting. OMH’s failure to intervene in this reality - its failure to state that there are individuals incapable of tolerating Attica SHU - pulls OMH staff away from professional integrity, and towards a hostile, cynical attitude towards those inmates. Overidentifying “malingering” and “manipulation” becomes a very convenient explanation, shielding staff from acknowledging its complicity in a situation which defies any standard of professional integrity.

An earlier class-action lawsuit concerning Bedford Hills Correctional Facility - Langley v. Coughlin, in which, as in this case, I served as one of plaintiff’s experts, addressed many of the same issues raised in Eng. The settlement of that lawsuit resulted in DOCS recognition that much of the bedlam prevailing in Bedford Hills SHU was a product of the mental illness prevalent there. DOCS agreed to transfer many of

these SHU inmates to a newly configured long-term residential program (an Intermediate Care Program - “ICP”) jointly administered by DOCS and OMH.

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Dr. Stuart Grassian

Dated: June , 1999
Chestnut Hill, MA

APPENDIX A

APPENDIX B

APPENDIX C

APPENDIX A
ENG STIPULATION REFERENCES TO PRIOR OMH RECORDS

The following reflect all of the Stipulation references to inmates' prior psychiatric records:

IA1 Requires the OMH staff to determine whether the inmate "is known to be at substantial risk of serious mental or emotional deterioration."

IB1 Requires the initial assessment to include a review of OMH records "to determine whether the inmate is on its active caseload, or has previously received mental health treatment while in the custody of DOCS."

IB2 Requires OMH to determine during the assessment whether "the inmate has a severe mental disorder or severe depression and is currently exhibiting symptomatology . . . or is at substantial risk of serious mental or emotional deterioration if sent to SHU."

IB3 Requires OMH to use the assessment information from the prior history to recommend a "plan for mental health treatment during the time the inmate is confined in SHU."

IB4 Requires OMH to specifically indicate in their assessment whether or not the inmate "has previously developed a severe mental disorder, suffered an acute exacerbation of a preexisting mental disorder or otherwise substantially deteriorated mentally or emotionally while in a special housing unit at any facility."

The seriousness of placing a mentally ill inmate into a SHU with knowledge of prior psychiatric deterioration in a SHU setting is specifically addressed by this provision:

3. A clinical decision to place an inmate with such a history into the SHU requires that the assessment includes the "basis for the conclusion" and "shall describe steps that will be taken to monitor the inmate for a recurrence of such symptoms while he is in SHU."

4. The provision also requires that this serious and risky clinical decision is to be "promptly review[ed]" by CNYPC "to ensure that it is consistent with the terms of this Stipulation." IG4.

IE The provisions of this section require that OMH continue with the treatment plans that inmates have on entry to the SHU and that a treatment plan review be performed within ten days of admission to the SHU to create a treatment plan "consistent with DOCS security requirements, but which also meets the standards set forth in the CNYPC Outpatient Record Manual."

IG4 Requires that CNYPC "promptly review" the decisions and documentation of OMH staff whenever "an inmate who previously had developed a severe mental disorder or suffered an acute exacerbation of preexisting mental disorder or otherwise substantially deteriorated mentally or emotionally in a special housing unit is approved for transfer to SHU."

The following provisions require that the inmate's OMH records properly reflect evidence of deterioration in SHU and the importance of providing services for inmates who are found to suffer psychiatrically in the SHU setting.

IC6 Requires that whenever OMH "determines that a SHU inmate has exhibited symptoms or behavior that his mental health is deteriorating . . . a further OMH mental health assessment" is required within one day.

IC7 Requires OMH to "request that the inmate be moved" when the re-assessment indicates "the inmate has developed a severe mental disorder or suffered an acute exacerbation of a preexisting mental disorder . . . or emotional deterioration if maintained in SHU."

IC8 For an inmate removed from SHU for "treatment or evaluation" a clinical conclusion that "the inmate may be returned to SHU . . . shall be documented" and "such documentation shall address any changes in treatment plan that reflect those issues which contributed to an inability to function in the SHU environment, a consideration of possible warning signs that may indicate that his mental health is seriously deteriorating and a plan to monitor for such signs." A decision to return an inmate to SHU is subject to "prompt" CNYPC quality assurance review. IG4

IF Requires OMH to keep records in accordance with "the requirements and standards as set forth in the CNYPC Outpatient Medical Record Manual."

INMATE A'S OMH RECORD PRIOR TO MARCH 1998

Inmate A was initially incarcerated in 1991, and from 1991 until June 1993 was housed at Downstate Correctional Facility. While there, he was noted to be seriously mentally ill, and was diagnosed as having a Bipolar Mood Disorder with Psychotic Features, along with a substance abuse problem. Towards the end of this period of incarceration - in April 1993 - he psychiatrically decompensated and was admitted in a psychotic, manic state to a Psychiatric Satellite Unit at Downstate.

In July 1993, Inmate A was transferred to Attica, where he was initially housed in general population. He was impulsive, at times agitated and hostile, and he was frequently keeplocked over the following months. In May 1994, Inmate A was stabbed in a fight in the yard at Attica, and shortly thereafter, he was transferred to involuntary protective custody, where over the next months, he began to psychiatrically decompensate.

By August 1994, when he was transferred from Attica to Great Meadow Correctional Facility, Inmate A was noted to have become once again manic and psychotic - agitated, incoherent, and delusional, with pressured speech and disorganized thoughts. He had developed the delusional belief that he had to drink excessive amounts of coffee, that spirits were talking to him, and that there soon would be blood.

At Great Meadow, Inmate A was noted to be wild eyed, agitated, his feet bouncing repetititvely on the floor; his mood was elated and excited, his thoughts racing, and his speech pressured. He was hearing voices - apparently of the judge who had sentenced him in his murder trial - telling him to "Die, die, die." He had the delusional conviction that this judge had orchestrated his stabbing several months

previously at Attica. These problems continued over the next months; in October 1994, for example he was described as highly agitated, fearful and delusional, believing he had to kill a Correctional Officer before this Officer killed him.

One month later, in November 1994, Inmate A was transferred from Great Meadow to Auburn. While housed there, he remained in a psychotic, fearful, agitated state. In March 1995, for example, he was noted to still be agitated, delusional, and with bizarre thinking and loose associations.

A few months later, in September 1995, Inmate A was transferred to Green Haven. He remained there until July 1997, when he was transferred to the Attica SHU. The records available to me shed little light on Inmate A's course in Green Haven after December 1995, when he was still apparently agitated, paranoid, and fearful of being killed. It would appear, however, that his psychiatric status must have improved substantially during this period of his incarceration, since his OMH needs level was changed at Green Haven at some point from Level 1 (the highest level of need) to Level 6 (not requiring mental health services).

In any case, in July 1997, Inmate A was transferred to the Attica SHU. Within one or two days of this transfer, he had become agitated, delusional and paranoid, and was noted to be experiencing auditory hallucinations of a voice (apparently this same sentencing judge) commanding him to kill himself and others, and specifically to kill himself by hanging. On July 10, 1997, his OMH needs level was changed once again to Level 1, and on that date he was admitted to the Attica Psychiatric Satellite Unit (an OMH satellite unit) on suicidal watch. He was refusing to eat because he believed the Correction Officers were poisoning his food, and he was noted to be confused and disoriented. The day after he was first housed in Mental Observation, he expressed relief because the judge had not carried through on his threat, and had left him in peace the previous night. He said that he was willing to go back to SHU as long as he could

be reassured that the judge would not visit him again.

By July 15, 1997, he was noted to be much improved - less agitated and confused, and without active suicidal ideation. He was then returned to SHU, and to a plexiglass-faced cell; his pleas that day to be placed in some alternative setting, were ignored.

Within two days, by July 17, 1997, he was noted to have become once again agitated and fearful. He began refusing to take the antipsychotic medication, haldol, which had been prescribed for him while he was in Mental Observation. Over the next months, he deteriorated psychiatrically. By September 10, 1997, when he was interviewed while he was behind plexiglass in the Attica SHU, he was noted to be agitated and disoriented, his speech pressured, and he was experiencing command hallucinations and delusional thoughts. He was convinced that his sentencing judge was going to visit his cell that night and question him, and that the judge would order him to hang himself with a noose made from his bed sheets tied to bars of his cell. He would have not choice but to follow the judges orders.

He had not attempted to kill himself over the following month, but he had apparently reported being visited by the judge. On October 10, he asked to receive part of his mental health record because the judge had ordered him to provide him semi-annual updates.

In January 1998, for no stated reason, Inmate A's OMH needs level was lowered from 1 to 2, a lesser level of need. He remained at Level 2 for the rest of his life. His actual mental health needs did not, however, in any manner correspond with this lower designation. Within a month, by February 12, 1998, he had become overtly agitated and delusional - convinced the fact that his nose was running was proof that the Attica staff were poisoning his food. He was having command hallucinations of the voice of his sentencing judge, ordering him to kill some Correction Officers. He was so agitated,

labile and confused - his thought processes illogical and disorganized - that he could not be engaged in any coherent conversation at all. He was placed in the Attica Satellite Unit, where the psychiatric team declared only: “Possible malingering.” Yet Inmate A remained delusional and strikingly disorganized; finally, on February 17, he was committed to CNYPC for treatment.