

Bates Range	Description
	Rosado, Maria 2/17/05
	Russell, Peter 3/25/04
	Sawyer, Donald 2/15/05, 2/16/05
	Selsky, Donald 2/3/04
	Shimkunas, Aligmantus 6/3/04
	Smith, Hal 4/28/05, 4/29/05
	Van Bramer, Jayne 10/1/04
	Way, Bruce 2/10/04, 2/3/05
	Woodward, Larry 3/24/04
	Wright, Lester 9/21/04
Inmate Disciplinary History Printouts	
DCSCOF 0006726-0008383, DCSCOF 0008443-0009075	List of 447 Inmates

Bates Range	Description

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	03 D 0001 Caroline B. 05 1 0002, 00100

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Bates Range	Description
CNYPC Policy and Procedure Manual Sections	
OMHCNY 0007916 – OMHCNY 0007931	Clinton Outpatient Mental Health Satellite Unit
OMHCNY 0007932 – OMHCNY 0008017	Sullivan Forensics Satellite Unit
OMHCNY 0008018 –	Diagnostic Clinic Manual

Bates Range	Description
OMHCNY 0008049	
OMHCNY 0008050 – OMHCNY 0008134	Education & Training Department
OMHCNY 0008135 – OMHCNY 0008210	EMSS Medical Services
OMHCNY 0008211 – OMHCNY 0008278	Department of Nursing
OMHCNY 0008279	Dietary
OMHCNY 0008280 – OMHCNY 0008284	Patient Care Services
OMHCNY 0008285 – OMHCNY 0008292	Department of Nursing Satellite Unit
OMHCNY 0008293 – OMHCNY 0008295	Department of Nursing
OMHCNY 0008296 – OMHCNY 0008298	Nutrition Services Department
OMHCNY 0008299 – OMHCNY 0008341	Department of Nursing/Satellite Unit
OMHCNY 0008342 – OMHCNY 0008419	Department of Nursing/Satellite Unit/Outpatient
OMHCNY 0008420 – OMHCNY 0008421	Pharmacy
OMHCNY 0008422 – OMHCNY 0008432	Department of Nursing
OMHCNY 0008433 – OMHCNY 0008449	Total Quality Management Support
OMHCNY 0008450 – OMHCNY 0008455	Infection Control
OMHCNY 0008456 – OMHCNY 0008477	Department of Nursing
OMHCNY 0008478 – OMHCNY 0008672	Health Information Management Department
OMHCNY 0008673 – OMHCNY 0008686	Uniform Case Record
OMHCNY 0008687 – OMHCNY 0008838	Uniform Case Record
OMHCNY 0008839 – OMHCNY 0008909	Total Quality Management
OMHCNY 0008910 –	Outpatient Medical Record Manual

Bates Range	Description
OMHCNY 0009043	
OMHCNY 0009044 – OMHCNY 0009101	Housekeeping
OMHCNY 0009102 – OMHCNY 0009132	Infection Control
OMHCNY 0009133 – OMHCNY 0009304	Housekeeping
OMHCNY 0009305 – OMHCNY 0009472	Human & Fiscal Resources
OMHCNY 0009473 – OMHCNY 0009711	Infection Control
OMHCNY 0009712 – OMHCNY 0009869	Information Center
OMHCNY 0009870 – OMHCNY 0010033	Maintenance Department
OMHCNY 0010034 – OMHCNY 0010122	Introduction
OMHCNY 0010123 – OMHCNY 0010144	Clinical Privileges
OMHCNY 0010145 – OMHCNY 0010630	Department of Nursing
OMHCNY 0010631 – OMHCNY 0011074	Department of Nursing
OMHCNY 0011075 – OMHCNY 0011124	Nutrition Services Coffee Shop
OMHCNY 0011125 – OMHCNY 0011331	Dietary
OMHCNY 0011332 – OMHCNY 0011395	MOU Between OMH & Division of Parole
OMHCNY 0011396 – OMHCNY 0011550	Outpatient Operations
OMHCNY 0011551 – OMHCNY 0011753	Patient Care Services
OMHCNY 0011754 – OMHCNY 0011825	Office of Mental Health
OMHCNY 0011826 – OMHCNY 0011857	Performance Improvement Plan
OMHCNY 0011858 – OMHCNY 0011899	Pharmacy Formulary
OMHCNY 0011900 –	Pharmacy

Bates Range	Description
OMHCNY 0012004	
OMHCNY 0012005 – OMHCNY 0012276	Psychiatric Rehabilitation and Activities
OMHCNY 0012277 – OMHCNY 0012326	Psychology Department
OMHCNY 0012327 – OMHCNY 0012353	Incident Reporting
OMHCNY 0012354 – OMHCNY 0012450	Risk Management
OMHCNY 0012451 – OMHCNY 0012544	Emergency Management
OMHCNY 0012545 – OMHCNY 0012553	Life Safety Management
OMHCNY 0012554 – OMHCNY 0012601	Fire Prevention
OMHCNY 0012602 – OMHCNY 0012725	Hazardous Materials and Waste
OMHCNY 0012726 – OMHCNY 0013179	Safe Environment
OMHCNY 0013180 – OMHCNY 0013219	Secure Environment
OMHCNY 0013220 – OMHCNY 0013257	Social Work Department
OMHCNY 0013258 – OMHCNY 0013274	Patient Care Services and Monitoring
OMHCNY 0013275 – OMHCNY 0013306	Utilization Management
OMHCNY 0013307 – OMHCNY 0013512	Volunteer Services
OMHCNY 0013513 – OMHCNY 0013541	Mental Health Unit: Albion Correctional Facility: Albion, NY
OMHCNY 0013542 – OMHCNY 0013564	Nursing Policy and Procedure
OMHCNY 0013565 – OMHCNY 0013590	Auburn Satellite Unit
OMHCNY 0013591 – OMHCNY 0013604	Bedford Hills
OMHCNY 0013605 – OMHCNY 0013639	Clinton Satellite Unit
OMHCNY 0013640 –	Elmira Satellite Unit

Bates Range	Description
OMHCNY 0013685	
OMHCNY 0013686 – OMHCNY 0013743	Five Points Satellite Unit
OMHCNY 0013744 – OMHCNY 0013777	Midstate Mental Health Unit
OMHCNY 0013778 – OMHCNY 0013823	Sing Sing Office of Mental Health
OMHCNY 0013824 – OMHCNY 0013851	Sullivan Correctional Facility
OMHCNY 0013852 – OMHCNY 0013883	Wende Mental Health Satellite
OMHCLI 0000273-0000278	Violence Risk Assessment and Prevention
No Bates	CNYPC Outpatient Medical Records Policy & Procedures Manual
No Bates	CNYPC Outpatient Operations Policy and Procedure Manual: Transfer Admission Policies
No Bates	CNYPC Outpatient Operations Policy and Procedure Manual: Referral, Admission, Transfer & Discharge Policies
No Bates	CNYPC Outpatient Operations Policy and Procedure Manual: Services to DOCS
Studies, Reports and Articles	
OMHCNY 108015-108025	Draft - DOCS/OMH Mental Health Service Development 1977 - 2005/2006 Prepared by NYS Department of Correctional Services and the NYS Office of Mental Health
PL 034826-034830	Steadman, Henry et al: "A Survey of Mental Disability Among State Prison Inmates," <i>Hospital and Community Psychiatry</i> , October 1987.
Plaintiff's Exhibit 3 PL 000570-000622	January 31, 1997 NYS OMH Task Force on the Future of Forensic Services Report of the Subcommittee on Prison Mental Health Services
OMHCNY 0064740- 0064818	Risk Management reports on Elmira suicides
PL 000657-000741	2/00 Correctional Association of New York report: Health Care in New York State Prisons
Plaintiff's Exhibit 231	11/00 Commissioner's Policy Paper on Prison

Bates Range	Description
PL 000521-000556	Safety & Inmate Programming
Plaintiff's Exhibit 80 OMHCNY 020483-020489	10/31/01 Report: "Analysis of Transfers to State Civil Hospital Inpatient Services from CNYPC"
Plaintiff's Exhibit 68 OMHCNY 054340-054352	11/26/01 draft of report: "State Prison Inmates with a Personality Disorder Diagnosis Receiving Inpatient or Outpatient Mental Health Services from CNYPC"
Plaintiff's Exhibit 69 OMHCNY 020470-020482	Rotter, Way, Steinbacher, Sawyer and Smith article: "Personality Disorders in Prison: Aren't They All Antisocial?" Winter 2002
Plaintiff's Exhibit 76 OMHCNY 041968-041981	2/20/02 Mental Health Observation Cell Usage in Mental Health Satellite Units operated by CNYPC (7/01-12/01 report)
OMHCNY 038303-038314	3/2002 CNYPC Inpatient Perception of Care Survey: March 2001 & October 2001
OMHFPO 0000012	3/19/02 STP Evaluation Behavioral Checklist for Security Staff
Plaintiff's Exhibit 71 OMHCNY 054353-054371	4/8/02 draft of report: "Quality Assurance Review of Suicides in New York State Correctional Facilities"
OMHCNY 042131-042160	4/22/02 CNYPC Inpatient Statistical Report: First Quarter 2002
Plaintiff's Exhibit 25 OMHCNY 043300-043333	SHU Mental Health Needs Study, B. Way, May 17, 2002
Plaintiff's Exhibit 9 OMHCNY 043262-043299	5/21/02 Review of the Intermediate Care Program, B. Way, K. Mahoney, M. Adams
OMHCNY 032507-032525	6/2002 CNYPC Inpatient Perception of Care Survey: March 2001, October 2001, & April 2002
OMHCNY 028747-028758	Smith, Sawyer and Way article: "CNYPC: An Approach to the Treatment of Co-Occurring Disorders in the New York State Correctional Mental Health System" June 17, 2002
Plaintiff's Exhibit 111 No Bates	August 2002 Bedford Hills Technical Assistance Final Report prepared by Angela Browne, "Addressing Self-Harm Among the Mentally Ill

Bates Range	Description
	and Traumatized Women in Prison: Avenues of Systematic Collaboration Between Mental Health and Correctional Personnel"
Plaintiff's Exhibit 77 OMHCNY 043223-043261	9/26/02 draft of report: Mental Health Crisis Observation Cell and Dormitory Bed Usage in the MH Satellite Units Operated by CNYPC (Findings July 2001 - June 2002)
OMHFPO 0000020	9/30/02 Attica/Five Points STP Evaluation
OMHFPO 0000021	9/30/02 Attica/Five Points STP Evaluation
OMHCNY 043175-043222	10/2/02 draft of Preliminary Report: Attica STP for Mentally Ill Inmates in SHU
OMHCNY 043141-043174	10/11/02 Preliminary Report: Five Points STP for Mentally Ill Inmates in SHU (Patients entering the STP Program between December 2001 through June 2002
OMHCNY 038344-038383	10/31/02 CNYPC Inpatient Statistical Report: Third Quarter 2002
OMHCNY 038315-038327	11/2002 CNYPC Inpatient Perception of Care Survey: March 2001, October 2001, April 2002, October 2002
Plaintiff's Exhibit 70 OMHCNY 043117-043140	11/13/02 report: "Suicide Risk Factors in New York State Prisons"
Plaintiff's Exhibit 67 OMHCNY 028600-028611	11/21/02 Report: CNYPC "Analysis of Mental Health Service Level Designations"
No Bates	Skeem, Monahan, Mulvey article: "Psychopathy, Treatment Involvement and Subsequent Violence Among Civil Psychiatric Patients," December 2002.
OMHCNY 0058807-0058814	12/20/02 CNYPC Inpatient Ward Reconfiguration Review
OMHCNY 108180-108196	Report on Outpatient Mental Health Services Provided by CNYPC in NYS Prisons in 2003
OMHCNY 082070-082104	Corrections Based Services/Inpatient Operations Annual Report for 2003

Bates Range	Description
OMHCNY 086773-086795	Report on Outpatient Mental Health Services Provided by CNYPC in NYS Prisons in 2003
No Bates	2003 Human Rights Watch Report: Ill-Equipped: U.S. Prisons and Offenders with Mental Illness
OMHCNY 108030-108067	Selected Management Indicators from Three Subgroups of OMH Units and Two Individual OMH Units which Provide Mental Health Services to SHU Inmates in NYS Correctional Facilities: January 2003 through January 2005
OMHCNY 028932-028937	1/17/03 CNYPC Patient Demographic and Diagnostic Profile: Inpatient & Outpatient (2003)
Plaintiff's Exhibit 79 OMHCNY 043100-043116	4/10/03 draft of report: "Transfers to Civil Psychiatric Inpatient Services from a Maximum Security Forensic Hospital"
Plaintiff's Exhibit 11 OMHCNY 043072-043099	4/17/03 study: CNYPC Review of Intermediate Care Program (ICP): (Participants in Program on 9/1/02)
Plaintiff's Exhibit 43 DCSCOF 0006726-0006734	Memo from Leslie Kellam (Program Research Specialist III) to John Culken (Dir MH Services), Doris Ramirez-Romero (Assistant Director MHS) and Tom Goetz (Senior Attorney) re: SHU Placement and OMH Levels dated June 24, 2003
Plaintiff's Exhibit 5 OMHCNY 042991-043034	7/21/03 study: Specialized Treatment Program (STP) for Mentally Ill Inmates in SHU at Five Points: Interim Evaluation Report (Patients entering the STP Program between December 2001 and May 2003)
Plaintiff's Exhibit 75 OMHCNY 042943-042990	7/23/03 draft of Interim Report: STP for Mentally Ill Inmates in SHU at Attica
Plaintiff's Exhibit 107 No Bates	10/03 Report by the Correctional Association of New York, "Lockdown: Disciplinary Confinement in New York State Prisons"
OMHCNY 108161-108179	Computed Selected Management Indicators for OMH Level 1 Mental Health Units in NYS Correctional Facilities: 2 nd , 3 rd and 4 th Quarters of 2004

Bates Range	Description
Plaintiff's Exhibit 359 PL 062682-062769	Correctional Association 2004 Report: "Mental Health In the House of Corrections"
Plaintiff's Exhibit 411 OMHCNY 0080337-0080380	SHUs in OMH Level 1 Correctional Facilities: Mental Health Needs Study, B. Way, July 16, 2004
OMHCNY 108005-108014	Review of Intermediate Care Program (ICP) Participants in Program on 3/1/05 Preliminary Report of Selected Variables
Documents Related to OMH Programs	
OMHCNY 026722-034218	Great Meadow and Mental Health Services in SHU
DCSCOF 0006057-0006061	Special Treatment Program - Five Points C.F.
OMHFPO 0000014-0000016	Orientation to Five Points STP
Plaintiff's Exhibit 133 OMHFPO 0000022-0000027	STP Screening Form
	Draft: Proposal for Behavior Management at Elmira CF
OMHCNY 0075661-0075667; 0079595; 0077225-0077227; 0077220-0077223; 0077210-0077216; 0069873-0069876	BMP List and RCTP Discussion
OMHCNY 075780-075805	John Wilson Assessments
OMHCNY 108068-108094	CNYPC System Overview
OMHCNY 108146	SHU and SHU200 NYS Prisons
OMHCNY 108453	Current Bed Capacities & Planned Expansion
No Bates	CNYPC Outpatient Program Guide (1995)
PL 055167-055209	5/22/98 SHU Manual; "The Marcy Plan" Marcy C.F.
PL 000557-000569	6/12/00 Mental Health Services Plan for SHU at Attica

Bates Range	Description
	6/12/00 Plaintiff's Declaration re: Mental Health Services Plan for SHU at Attica
Plaintiff's Exhibit 49 DCSCOF 0006044-0006056	6/12/00 Mental Health Services Plan for Special Housing Unit Patients at Attica Correctional Facility
Plaintiff's Exhibit 310 OMHATT 0001054-0001084	Specialized Treatment Program Attica C.F. - 12/20/00 - 4/6/01
	1/17/01 Double Occupancy Housing Units
OMHCNY 043347-043376	2/3/01 draft: Mental Health Services Plan for Special Housing Unit Patients at Attica Correctional Facility
OMHATT 0001085-0001118	Specialized Treatment Program Attica C.F. - 4/23/01 - 7/13/01
OMHCNY 0013884-0013938	5/4/01 Policy and Procedure Manual for Attica Satellite Unit
OMHATT 0001119-0001155	Specialized Treatment Program Attica C.F. - 7/23/01 - 10/19/01
OMHATT 0001156-0001184	Specialized Treatment Program Attica C.F. - 11/5/01 - 2/5/02
OMHATT 0001185-0001253	Specialized Treatment Program Attica C.F. - 2/19/02 - 5/10/02
OMHCNY 027803-027837	4/18/02 Mental Health Services Plan for Five Points SHU
Plaintiff's Exhibit 9 OMHCNY 043262-043299	5/21/02 Review of the Intermediate Care Program at CNYPC
OMHATT 0001254-0001325	Specialized Treatment Program Attica C.F. - 5/28/02 - 8/26/02
PL 063079-063084	Draft Summary of Prison Visiting Committee Tour of Attica (for 9/17/02 & 9/19/02 tours)
OMHCNY 043175-043222	10/2/02 Attica Special Treatment Program Preliminary Report
OMHCNY 043141-043174	10/11/02 Five Points Special Treatment Program Preliminary Report

Bates Range	Description
PL 052467-052470	10/28/02 Correctional Association of New York Letter to Five Points Superintendent
OMHCNY 028921-028927	12/30/02 Correctional Association of New York letter to Attica Superintendent
Plaintiff's Exhibit 33 OMHCNY 0057521-0057528	1/03 Intermediate Care Program Plan of Correction
Plaintiffs Exhibit 418 No Bates	7/03 - 3/04 Bureau of Mental Health Quality Assurance/Quality Improvement Report
Plaintiff's Exhibit 11 OMHCNY 043072-043099	4/17/03 Review of the Intermediate Care Participants in 9/1/02
OMHCNY 081790-081833	CNYPC Patient Demographic and Diagnostic Profile (2004)
No bates stamp	Great Meadow BHU Manual, December 16, 2004
No bates stamp	Behavioral Health Unit Program Operation Description, 2005
No bates stamp	Sullivan BHU Manual, February 24, 2005
Letters, Memoranda, and E-mail	
OMHCNY 0074819-0074858	E-mails re: Behavior Management Plans
Plaintiff's Exhibit 399 OMHCNY 0080491	E-mail from Sawyer to Unit Chiefs re: Case Management Committees
OMHCNY 108454-108457	Memo from Donald Sawyer to CNYPC Unit Chiefs re: Special Housing Unit Plan of Improvement
Plaintiff's Exhibit 358 OMHCNY 0079526-0079542 Plaintiff's Exhibit 522 OMHCNY 094133 Plaintiff's Exhibit 523 OMHCNY 094149 Plaintiff's Exhibit 524 OMHCNY 094154 Plaintiff's Exhibit 538 OMHCNY 097199-097231	E-mail related to keeping MH Level 1 inmates on caseload:

Bates Range	Description
	2/23/99 Letter from Goord to Stone
OMHCNY 0010405-0010449	7/20/99 Memorandum of Understanding between the New York State Office of Mental Health and the New York Department of Correctional Services
PL 000653-000654	9/1/99 Letter from Goord to Stone
PL 000653-000654	9/1/99 Letter from Commissioner Goord to Commissioner Stone regarding recent meeting on mental health service delivery system in the DOCS
Plaintiff's Exhibit 270 DCSOF 0010672-0010677	9/24/99 Letter from Smith to Polan re: CNYPC Satellite Units: Residential Crisis Utilization
PL 000655-000656	2/23/00 Letter from Commissioner Goord to Commissioner Stone regarding mental health services to inmates
No bates range	12/11/00 Letter re: Double Occupancy Housing Units
Plaintiff's Exhibit 551 OMHCNY 093379-093381	2/21/01 E-mail from Way to Dorman et al. re: Prevalence in Other States - Med Over Objection
OMHCNY 0077640-0077641	8/1/01 Email from L. Farago to multiple people re: Diagnosis
No Bates	5/14/02 e-mail from Kellam re: SHU Population on 1/15/02
OMHCNY 034219-034220	5/24/02 E-mail from Dan Abreu with attached notes from the special meeting on SHU and ICP
DCSCOF 0014453-0014454	5/31/02 memo to Les Wright from Paul Korotkin re: OMH Level 1's in SHU
No Bates	7/18/02 e-mail from Kellam re: Reply to OMH Levels in SHU;
No Bates	7/26/02 e-mail from Aziz re: Reply to OMH Levels in SHU;
No Bates	8/9/02 e-mail from Kellam re: SHU/OMH
OMHCNY 082430	8/16/02 E-mail from Taintor to Smith re: Attica - Reply
Plaintiff's Exhibit 219	e-mail from Peter Russell to Donald Sawyer re:

Bates Range	Description
No Bates	te Placement
No Bates	6/10/03 memo from Kellam to Culkin et al. re: SHU Placements and OMH Levels;
OMHCNY 043035-043039	6/25/03 Memorandum from Donald Sawyer to CNYCP Unit Chiefs re: SHU Plan of Improvement
Plaintiff's Exhibit 72 OMHCNY 043035-043039	6/25/03 Memorandum from Donald Sawyer to CNYPC Unit Chiefs regarding Special Housing Unit Plan of Improvement
OMHCNY 090715	9/15/03 e-mail from Sawyer to unit chiefs - Case Management Committee Expectations
Plaintiff's Exhibit 555 OMHCNY 091628-091629	12/4/03 E-mail from Sawyer to Smith and Way re: My notes from the CQC Presentation
OMHCNY 064888-064890	1/24/04 e-mail from Peter Russell to Donald Sawyer re: Behavior Management Proposal
OMHCNY 0064865-0064868	2/2/04 E-mail from P. Russell to C. Antenore et al re: Revised SHU Plan of Improvement
Plaintiff's Exhibit 459 OMHCNY 089614-089615	2/3/04 e-mail from Sawyer to Way, Smith, & Miraglia re: Fwd: help/quick
PL 065804	3/4/04 Letter from N. Loewenstein to H. Smith re: Robert Houston
Plaintiff's Exhibit 257 OMHGM 0010614	4/2/04 e-mail from Al Shimhunas to Deborah Kahkejian re: Great Meadow New SHU Study Data
Plaintiff's Exhibit 460 OMHCNY 091069-091070	5/18/04 e-mail from Beer to Klingman re: SHU Caseloads
OMHCNY 087954-087961	7/22/04 E-mail from D. Van Heusen to R. Miraglia re: Draft - CNY - Additional Geo. Differential Request
OMHCNY 097199-097231	10/1/04 E-mail from Barboza-Whitehead to Sawyer, Smith and Lee re: BMP Effectiveness Study draft
OMHCNY 100612-100614	11/22/04 e-mail from Way to Briney, Petrino and Sawyer re: model for CMCs
OMHCNY 108239-108297	Email from David Barry to cnopdas@omh.state.ny.us re: BHU Presentation

Bates Range	Description
	(Behavioral Health Unit Training Agenda For Great Meadow BHU Draft 4/3/05 attached)
Meeting Minutes	
OMHCNY 046208-046212; 046215 OMHCNY 046198-046200; OMHCNY 0003832- 0003834; OMHCNY 046217-046219; OMHCNY 046177-046179; OMHCNY 0003809- 0003812; OMHCNY 046125-046127; OMHCNY 0077551; OMHCNY 0077124- 0077126	Select CNYPC Ethics Committee Meeting Minutes
Exhibits 396, 397, 398	Albion CMC Meeting Minutes
OMHCNY 095760-64 OMHCLI 0000127-35, 218-253, 196-197, 254-57, 0000146-47, 286-294, 261-2, 305-06 OMHFPO 0000028-31, 34- 55, 57-82, 0001689-92, 0001457-59, 1453-56, 1411-16, 1502-05, 1544-48, 1320-25, 1368-70, 1591-94, 1272-77, 1639-46, 1738-40, 1828-29, 1868-72, 1914-62 OMHSS 0003284-85, 3452- 57, 3449, 3424-25, 3406- 3409, 3422-23, 3410-11, 3420-21, 3412-19, 3389-92, 3311-12, 3323-24, 3321-22, 3313-14, 3319-20, 3327-28, 3325-26, 3343-44, 3335-38, 3347-48, 3339-40, 3331-2, 3345-46, 3333-34, 3341-42,	Select JMC/CMC Meeting Minutes for Clinton, Five Points, and Sing Sing Correctional Facilities

Bates Range	Description
3329-30, OMHCNY 95747-50 OMHSS 0003393-96, 3385-88, 3383-84, 3381-82, 3373-74, 3379-80, 3371-72, 3375-78, 3357-58, 3355-56, 3359-60, 3351-54, 3349-50, 3369-70, 3365-68, 3363-64, 3361-62, 3317-18, 3315-16	
Plaintiff's Exhibit 26 OMHCNY 034215-034218	5/22/02 Satellite Roundtable Meeting Minutes
OMHCNY 042391-042409	7/29/02 Operations Committee Meeting Minutes; John Wilson's presentation: Overview to CNYPC Operations Committee/Behavior Management
OMHCNY 032557-032597	8/5/02 Operations Committee Meeting Minutes; 7/26/01 CNYPC Inpatient Statistical Report: Second Quarter 2002
SCOC 001564-001567	SCOC Medical Review Board Meeting Minutes 9/4/03
Other	
DCSCOF 0006414-0006550	Special Housing Unit-Mental Health Training Program
	Anderson training video: "Consideration of Mental Impairments in the Inmate Disciplinary Program"
No bates range	<u>Eng v. Goord</u> Rule 41 Voluntary Stipulation of Dismissal Subject to Conditions
	<u>Eng v. Goord</u> , Civ 80-385S, Amended Rule 41 Voluntary Stipulation of Dismissal Subject to Conditions
	A Hearing Officer's Guide to the Superintendent's Hearing
	<u>Reed v. Scully</u> , 531 N.Y.S. 2d 196 (1988 N.Y. Sup. Ct.)
	<u>Huggins v. Coughlin</u> , 548 N.Y.S. 2d 105 (1989

Bates Range	Description
	App. Div. 3d Dept.)
	<u>Gittens v. Coughlin</u> , 541 N.Y.S.2d 718 (1989 N.Y. Sup. Ct.)
	<u>Huggins v. Coughlin</u> , 561 N.Y.S.2d 910 (1990 N.Y. Ct. of Appeals)
	12/4/00 Testimony of Sarah Kerr to NYS Democratic Task Force on Criminal Justice Reform
	2/8/02, Letter to Assistant Attorney Generals in <u>Eng v. Goord</u> (redacted version)
	DAI v. OMH Complaint filed 5/28/02
	Suicide Chart as of 6/11/02, created by Plaintiff's Counsel
	MH Housing by Facility Table prepared by Legal Aid Society
	Charts created by Plaintiff's Counsel: -SUICIDERECORDS.sk -Notes_on_chart.sk -otherdeaths.sk -SUICIDEcharacteristics.sk
No Bates	Tables created by DPW detailing inmates whose diagnoses changed between the publication of the OMH 2002 SHU Study and the OMH 2004 SHU Study
	Document Requests: Plaintiff's First Request filed 9/6/02 Plaintiff's Second Request filed 4/1/03 Plaintiff's Third Request filed 5/1/03 Plaintiff's Fourth Request filed 6/11/03 Plaintiff's Fifth Request filed 7/18/03 Plaintiff's Sixth Request filed 8/20/03 Plaintiff's Seventh Request filed 9/26/03

Bates Range	Description
	Plaintiff's Eight Request filed 11/10/03 Plaintiff's Ninth Request filed 11/21/03
	DAI's First Set of Requests to Admit dated 4/14/05
Plaintiff's Exhibit 256 No Bates	Anderson Training Document: 4/14/04 e-mail from Al Shimkunas to Wurzberger et al. re: OMH Testimony in Tier Hearings (PowerPoint Presentation attached)
DCSCOF 0000387- 0000419; 0004272- 0004336; 0006082- 0006160; 0006337- 0006355; 0006367- 0006413; 0006440- 0006443; 0006473- 0006494; OMHCNY 0005777- 0005779; 0007374- 0007396; 0025715- 0025898; 0034410- 0034413; OMHDS 0000060-0000063; OMHELM 0000033- 0000035; 0000088; OMHGM 0000183- 0000184; OMHMS 0000112- 0000137; OMHSUL 0000134; PL 048594-048837	Documents related to Suicide Training and Suicide Prevention
Videotapes	10/26/99 P.N. : Cell Extraction and Strip Frisk 3/5/00 F.F.Z. Interview with OMH 7/25/94 K.K. Removal to Hospital 5/21/03 Y.B. Observation 11/10/4 Y.H. Removal to Observation

Bates Range	Description
	5/15/01 P.T.): Disciplinary Hearing (audiotape)
OMHBH 0001747-0001885 OMHBH 0001139-0001442 OMHBH 0002493-0002750 OMHBH 0001443-0001746 OMHBH 0000813-0001002	Log Books: Bedford Hills: Satellite Unit (10/25/02-4/1/03)
	DAI v. OMH Case Management Order dated 6/23/04
OMHCNY 085617-085620 OMHCNY 085660-085668 OMHCNY 086678-086701 OMHCNY 086702-086733 OMHCNY 086734-086747 OMHCNY 086748-086763 OMHCNY 087555-087577 OMHCNY 087795-087800	Documents from Defendant's 11/08/04 production
No Bates	CV of Richard Miraglia
OMHCNY 089648, 045455-045459, 060991- 060993, 045300-045303, 089931-089933, Pls. Ex. 104, 090060-090064	Documents related to HARE test
Plaintiff's Exhibit 242 OMHGM 0000115- 0000117	CNYPC - Outpatient Satellite at Great Meadow Correctional Facility
OMHCNY 0066743 OMHCNY 0066741-2 OMHCNY 0077284-85 OMHCNY 0077291-2 OMHCNY 0078832-3	Documents re: Traveling Rivers' Orders

Bates Range	Description
OMHCNY 0077304-5	
OMHCNY 108450-108452	SHU Mental Health Statistical Tables
Plaintiff's Exhibit 568 OMHCNY 0060985-0060990	Obtaining Prior Mental Health Records for Patients admitted to Service at Downstate Correctional Facility
OMHCNY 027050-027072	9/18/02 Quality of Life Instrument
Plaintiff's Exhibit 238 No Bates	2004-05 Executive Budget Forensic Mental Health Initiatives
<i>Plaintiff's Exhibit 220</i> <i>No Bates</i>	3/8/04 Final SCOC Report: David Estime
OMHCNY 036787-036801	Letter from Dr. Goyal, M.D., Dir. Medical Services to Dr. Menon, Clinical Director re: Docs Medical Clearance Form
OMHCNY 046726-046727	Incident Review Report of Z.R.
OMHCNY 046871	Incident Review Report of G.G.B.
OMHCNY 046829-046843	Incident Review Report of G.G.C.
OMHCNY 044651-044653; 045206	Memo from Aileen Townsend, ACSW, DPA to Dr. Buscema re: Anthony Burton Investigation
OMHCNY 044654-044690	CNYPC Medical Staff Meeting
OMHCNY 044691-044703	Statewide Medical Staff Meeting Beeche's Conference Center
OMHCNY 044725-044726	Central New York Psychiatric Center Incident Review Committee Meeting,
OMHCNY 046750-	Incident Review Report of G.A.
OMHCNY 044727-044730	Central New York Psychiatric Center Incident Review Committee Meeting,
OMHSS 0000088	Letter from Jurgen Karker, to Unit Chiefs, Level 1 Facilities re: Follow up of Patients discharged from RCTP to SHU
OMHSS 0000092	E-mail from Bradigan to Devito, et al. re: Change in Mental Health Level Policy
OMHSS 0000123	Sing Sing Satellite Unit Goals and Objectives
OMHCNY 053434	5/4/00 Memo from DeVito to Donnelly re: Breakdown of No Show/Callouts – Mental Health Month of April 2000
OMHCNY 025976	1/26/00 Letter from Smith to Miraglia re: CNYPC Overtime Expenditures

Bates Range	Description
OMHCNY 047045	Memo from Buscema to Physicians et al. re: PCM's on Patients Discharged from CNYPC & Returning to a SHU Environment
OMHCNY 044770-	CNYPC Incident Reporting Policy and Procedure Manual re: Filing of Criminal Charges Against a Patient
OMHCNY 0010405-0010449	Memorandum of Understanding Between the New York State Office of Mental Health and the New York State Department of Correctional Services,
OMHBH 0003636-0003643	Bedford Hills Evaluation, Bedford Hills Satellite Unit Evaluation of Operating Systems
DCSCOF 0006044-0006056	MH Services Plan for SHU Patients at Attica, 6/12/00
OMHGM 0000158-0000160	Great Meadow Satellite Unit Principal DSM IV Diagnoses
DCSCOF 0005732-0005733	Justification for the Need for Additional Nurses at Level 2 Facilities
OMHCNY 053410-053419	CNYPC Performance Improvement Proposal, Callout Compliance Rate
DCSCOF 005734-0005735	Memo to M. Prisco from C. Frater re: OMH inmates on Psychiatric medications
OMHCNY 026023-026024	7/20/00 Letter from R. Miraglia to A. Holmes RE: Forensic Overtime
OMHCNY 047164-047172	8/00 IRC Meetings
OMHCNY 056580-056584	Performance Improvement Forum Meeting 8/16/00
OMHCNY 053389-053391	CNYPC Outpatient Performance Improvement Projects (2000), (Updated 9/19/00)
OMHCNY 056826-056836	CNYPC Outpatient Performance Improvement Cover Sheet
OMHCNY 047116-047118	IRC Meeting 11/15/00
OMHCNY 056568-056571	Performance Improvement Committee Meeting 11/16/00
OMHSS 0002733-0002740	12/5/00 Memo from Bord to Adams re: JCAHO Mock Survey
OMHCNY 053303-053309	CNYPC Outpatient Performance Improvement Projects (2000) (Updated 12/11/00)
OMHCNY 053443-053447	12/13/00 Memo from Lauve to Performance Improvement Committee Members re: Performance Improvement Committee Meeting Minutes 11/16/00

Bates Range	Description
OMHCNY 056502-056509	Performance Improvement Forum Committee Meeting
OMHCNY 047102-047107	IRC Meeting 12/13/00
OMHSS 0000178	12/21/00 Memo from Boyd to Perilli re: SHU Training Feedback
OMHGM 0000013-0000015	Memo from Greasley to Shimkunas re: Justification for Sixth Nurse
OMHCNY 043347-043376	Draft, Mental Health Services Plan for Special Housing Unit Patients at Attica Correctional Facility Submitted by the NYS Office of Mental Health and the NYS DOCS
OMHSS 0002775-0002781	Letter from Roland Cote to Doris Ramirez-Romero, re: Sing Sing ICP Monthly Report
OMHBH 0000165	Letter from Michelle A. Petrino Unit Chief OMH to Capt. Ballte and Capt. Gladding re: SHU/PMH Training
OMHCNY 030773-030839	CNYPC Environment of Care Performance Program Report Monthly/Quarterly/Annual Report
OMHBH 0000159-0000164	SHU Rounds Schedule – 2001
OMHBH 0000158	Memo from Sheryl L. Salaris to Michelle Petrino re: Langley Stipulation
OMHCNY 056868-056884	CNYPC Performance Improvement Proposal Coversheet: Improvement of Patient Escort Rates
OMHCNY 056860-056867	CNYPC Performance Improvement Proposal Coversheet: Reducing Redivison of Patient Transfers to RCTP
OMHCNY 056885-0569191; OMHGM 0000130-0000131	CNYPC Performance Improvement Proposal – Callout Compliance Rate; 5/7/01 memo from Shimkunas to Duncan re: Continuation of Restricted Diet in Observation Cells
OMHCNY 056535-056538	Performance Improvement Forum Committee Meeting
OMHCNY 047703-047706	Psychological Autopsy of. A.S. (died 5/14/01)
OMHCNY 056820-056825	CNYPC Performance Improvement Proposal Coversheet: RCTP Release to Departure Study
OMHGM 0000149	E-mail from Shimkunas to Don (Sawyer) re: OMH Levels in SHU
OMHCNY 047720-047729	Memo from Herrmann to Smith, Farago, Sawyer, & Buscema, re: Psychological Autopsy Report – Patient E.F.

Bates Range	Description
OMHCNY 043334-043339	Clinton Satellite and Catchment Evaluation of Operating Systems
OMHCNY 045180-045185;	Memo from Spriggs to Herrmann re: Shane Maxwell, attaching Root Cause Analysis & Action Plan in Response to Sentinel Event
OMHCNY 043340-043346	Memo from Sawyer to Smith re: Clinton Satellite Unit Visit Reports and Recommendations
OMHCNY 047681-047683	Morbidity/Mortality Review Committee Meeting Minutes
OMHCNY 041968-041981	Draft: Mental Health Observation Cell Usage in the Mental Health Satellite Units Operated by Central New York Psychiatric Center Report July-December 2001
OMHCNY 047751-047760	Documents re: death of <u>J.I.</u> including Incident Review Committee Meeting Minutes, e-mails, and Report of Special Investigation
OMHGM 0000016 OMHCNY 090350	E-mail from Shimkunas to Smith re: Operational Problems Re SHU
OMHGM 0000154	E-mail from Al Shimkunas to Donald Sawyer re: SHU Follow-up
OMHCNY 054353-054371	Draft Quality Assurance Review of Suicides in New York State Correctional Facilities
OMHCNY 027803-027837	Memorandum from Sawyer to Miraglia et al. re: STP Program Description – 5 Points Correctional Facility
OMHCNY 034140-034153	Memo from Herrmann to Miraglia, re: CNYPC Quarterly Incident Statistic Report
OMHSS 0002758-0002761	Message from Superintendent, Sing Sing Correctional Facility to David Boyd re: SHU Committee
OMHGM 0000152-0000153	E-mail from Shimkunas to Sawyer et al. re: Great Meadow Observation Overflow Reduction
OMHCNY 056471-056477	Performance Improvement Forum Committee Meeting Minutes
OMHCNY 034215-034218	Satellite Roundtable Meeting
OMHSS 0002756-0002757	E-mail from Culkin to Boyd re: Reply to Sing Sing SHU
OMHCNY 047742-047744	Letter from Herrmann to Farago re: Incident Investigation Recommendation(s) re: death of <u>G.G.P.</u>

Bates Range	Description
OMHSS 0002754-0002755	E-mail from Spriggs to CN Unit Chiefs re: SHU Private Interview Letter, Monitoring Form and Progress Note
OMHCNY 047730-0047733	Morbidity/Mortality Review Committee Meeting
OMHGM 0000148	Memo from Shimkunas, to OMH Clinicians on SHU Rounds re: 24 Hour Screenings
OMHSS 0002763-0002771	Special Housing Unit Multi-Agency Review Committee on Inmates with Active Mental Health Cases
OMHCNY 056451-056460	Performance Improvement Forum Committee Meeting
OMHCNY 043223-043261	Mental Health Crisis Observation Cell and Dormitory Bed Usage in the Mental Health Satellite Units Operated by CNYPC July 2001 – June 2002 Draft
OMHGM 0000146	E-mail from Shimkunas to Privett re: SHU Contacts/Operations
OMHCNY 043175-043222	Attica Special Treatment Program (STP) for Mentally Ill Inmates in Special Housing Units, Preliminary Report Patients entering the STP Program Between November 2001 and May 2002 (Draft)
OMHSS 0000142-0000143	E-mail from Mahoney to ICP Coordinators re: Fwd: DOCS ICP Budgets
OMHCNY 043141-043174	Five Points Special Treatment Program (STP) for Mentally Ill Inmates in Special Housing Units Preliminary Report Patients entering the STP Program between December 2001 through June 2002
OMHCNY 053494-053497	CNYPC Outpatient Performance Improvement Projects (2002), (Updated 10/25/02)
OMHSS 0000101	Email from Leclair to Wilhem et al. re: OBS Cell Discharge Procedure
OMHSS 0002762	E-mail from Key to Fischer and Kikendall re: F/U 11/8 Meeting

D

7/18/2020

APPENDIX D

NEW YORK DOCS INTERVIEWS OF 183 PRISONERS

by Terry A. Kupers, M.D., M.S.P.¹

Elmira Correctional Institution – 3/11/03

List of 9 Inmates

Southport - 3/12/03

List of 6 Inmates

Five Points Correctional Institution – 3/13/03

List of 15 Inmates

¹ The list of prisoners interviewed by me is complete. However, the case studies that follow in this Appendix C include only those cases that are not included in the foregoing Report.

Clinton Correctional Facility – 7/15 – 7/16/03

List of 21 Inmates

Upstate Correctional Facility – 7/17 – 7/18/03

List of 9 Inmates

Sullivan Correctional Institution – 5/5/03

List of 10 Inmates

Bedford Hills Correctional Institutional – 5/6/03

List of 11 Inmates

Sing Sing – 5/7 – 5/8/03

List of 25 Inmates

Great Meadow – 8/26 – 8/27/03

List of 26 Inmates

Wende Correctional Institution – 9/22/03 and 9/25/03

List of 19 Inmates

Attica Correctional Institution – 9/23/03

List of 7 Inmates

Albion Correctional Institution – 9/24/03

List of 9 Inmates

Auburn Correctional Institute – 10/29/03-10/30/03

List of 19 Inmates

Elmira Correctional Institution – 3/11/03

D. D. Z.

(Interviewed while housed in RCTP).

Mr. D. D. Z. who had previously been in ICP, cannot remember how old he is, is disoriented to place and confused about person, and cannot remember when he came to prison. His conversation is confused and he talks nonsense. There is bizarreness and strange affect. There are lapses in his train of thought. He says that the medications he takes do not work. He tells me he has tried to hang himself at CNYPC. He is currently awaiting transfer to CNYPC. He is too incoherent to give a history. This man is acutely psychotic and probably suffers from an organic brain disorder as well. His clinical chart fills a carton. He has a long history of Schizophrenia with command hallucinations. He was admitted to public psychiatric hospitals several times prior to incarceration. There was significant drug use, including possible effects of illicit drugs during commitment offenses. He began this bit in 1998, being sent from Downstate Reception to CNYPC, but he has been repeatedly admitted to CNYPC since 1987 (prior bit?). He has been very suicidal, including cutting his neck, arms, genitals, etc. He is consistently noted to be agitated with flight of ideas, severe thought disorder and hallucinations and delusions. He is repeatedly admitted to CNYPC, diagnosis Undifferentiated Schizophrenia. He is prescribed a cocktail of anti-psychotic, mood stabilizing and antidepressant medications, with minor tranquilizers and sleep aides thrown into the mix. He becomes non-compliant with medications, decompensates and/or becomes suicidal, and returns to CNYPC. ICP is probably the best place for him within DOCS when he is relatively stable and can be out of a hospital.

Example of:

Acute psychosis in RCTP

Treatment in ICP for SMI

C. C. L.

(Interviewed while housed in RCTP).

C. C. L. arrived from the Southport SHU six days before our interview. He had been in SHU for two months on account of an incident at Auburn (he says he refused DNA testing). He entered prison in 1989. He tells me he attempted suicide by overdosing on medications, and he really wants to die – he is intent on accomplishing suicide. He has been prescribed psychiatric medications since 1996 or 1997, but is not currently taking any. On mental status examination he is clearly depressed, cries as we talk, and exhibits psychomotor retardation with a sense of hopelessness and helplessness. He says he paces incessantly in his cell, does not dream any more, and that his depression is made much worse when he is in SHU. He is bothered by the fact that all the prisoners in the SHU seem angry. The fact that nobody visits him, and he is serving a 22 year to life prison term, increase his depression and despair. He says he is on the OMH caseload, but does not take medications. He complains that he is viewed as assaultive, even though he has not had tickets during 15 years in prison.

Example of:

**Severe depression worse in SHU
Southport SHU w SMI**

Y.H.

(Interviewed while housed in RCTP).

Y.H. has been in prison for four years and tells me he is slated for release in November. He transferred to observation from SHU. He has never been to CNYPC, but this is his second time in RCTP at Elmira, and he was also in the Mental Health Unit at Five Points twice and twice at Sing Sing. He takes antidepressant medications because of "stress." He says he goes to the crisis unit because he is beaten by staff in the SHU. He avers agitation and insomnia, and says he repeatedly cuts himself in order "to get away from abuse by the COs." He says he was beaten by officers after trying to hang himself. He has asked for protection which has been refused. He claims officers are constantly retaliating against him. He claims other prisoners in SHU throw feces at him. On mental status examination he seems to have ideas of reference, but is otherwise coherent with intact thinking, orientation and relating. He had a psychiatric history prior to incarceration, including seeing a psychiatrist because of family problems and then trying to shoot himself in the head prior to incarceration. His clinical chart includes a 3/20/03 Admission to CNYPC, for self-destructive behavior, seen as non-psychotic impulse control problem. A 1998 admission to Bellevue psychiatric ward is noted. At other times, hallucinations are noted. There is a 10/2/02 admission note to observation with a diagnosis of Impulse-Control Disorder & MH Level 1. On 10/23/02 his medications include Remeron 30 mg, Trazadone 100 mg. and Trilafon (an anti-psychotic agent) 4 mg. b.i.d. Previously he had been prescribed Risperdal and Seroquel (both anti-psychotic agents) and Zoloft. On 4/15/03 he is placed on a "Behavior Plan" in SHU. In May, 2003, several notes report his wish to go to ICP. In other words, this man spends significant amount of time in SHU, becomes suicidal or self-destructive, and cycles to observation. He is prescribed antidepressant and anti-psychotic medications. His report of hallucinations is questioned. He is also reported to have a seizure disorder.

Example of:

**Severe depression, worse in SHU
Cycle to observation & back to SHU
Also un-diagnosed at CNYPC**

P.A.

(Interviewed while housed in SHU).

P.A. has been in prison for eight years. He is interviewed while in SHU, where he has been for four months. Just prior to our interview he learned a disciplinary hearing decision was reversed because there was no consideration given to his mental health status, and now there will be a new hearing. He says he has had "mental problems" all of his life, and is currently taking Zyprexa, 5 or 10 mg. per day. He has been at CNYPC. He complains about the MHU, "any time you have a mental problem you get stripped and searched." About SHU: "The mental health staff come around the

SHU, but merely talk to you through your food slot." He reports he has been hearing voices his whole life, and with the right medications "I can deal with it." He complains that other prisoners in the SHU suffer from mental illness to such an extent that they bang on their doors, or scream, or otherwise cause a nearly constant commotion. He complains that the officers "hold onto your food and play with you." He gets headaches, and the voices get louder, when he is alone in a cell in SHU. He gets desperate to get out because "it's upsetting to be cut off from the world." He gets paranoid in SHU. "Officers control mail and everything, and when they cut off the radio, you don't know what's going on." When the officers come by and ask him how his food tasted, he worries that they are putting something in it. Officers do not respond when a prisoner calls them. On the swing shift, the officers come around only two times in eight hours. He loses sleep in SHU, and that makes his mental illness worse. He is unable to concentrate, and cannot read as well as usual – which depresses him. An officer walks around with the nurse who passes out medications, and that officer "messes with people." The night prior to our interview he paced in his cell for four or five hours. While he told the police he'd done more drugs, he actually only smoked marijuana. He finished tenth grade, and never received a GED in prison because he has spent so much time in the box. He has received 50 tickets in DOCS, most of them involving command hallucinations telling him to do the illegal acts, usually fighting. He reports he has told mental health staff about that, but they ignore him, so he has stopped telling them. And Dr. Fontana has told him that "if you pull this psychotic routine again we're going to strip you down." When he was in observation, he smeared and threw excrement in response to voices telling him to do so. On mental status exam there is flatness, concreteness, history of hallucinations and delusions, and very strong First Rank Symptoms. In other words, this man, by history and mental status examination, suffers from active psychosis, and needs to be removed from SHU and placed in a mental health treatment setting such as ICP.

Example of:

Actively psychotic in SHU

Condition much worse in SHU

Disciplinary infractions secondary to SMI

H.O.

(Interviewed while housed in SHU).

H.O. had been in SHU since August of 2002. He had a history of severe anxiety and was prescribed Elavil and Valium in the community prior to incarceration. He says he has been to CNYPC five times since entering prison in 1980. He has repeatedly tried to kill himself and has been in observation on multiple occasions. Being in a SHU cell causes him to become much more anxious; in SHU, he chews his fingernails, cannot sleep except with the medications he is prescribed, cleans his cell three or more times per day, thinks a lot about killing himself but is dissuaded by thoughts of how terrible it is to be in observation, and sees the "doctor" once a month. His clinical chart reflects he has been in prison this term since Feb., 1997, and had an admission to CNYPC in 1997. He came in as a MH Level 2, and has been changed to 1. He carries a diagnosis of Psychotic Disorder NOS, Cocaine abuse and ASPD, with a

GAF of 40 on 3/22/99. In a 1987 admission note to CNYPC a long history of self-mutilation and swallowing foreign objects is noted, and he is diagnosed Adjustment Disorder with mixed features and ASPD. An 8/10/89 admissions note to CNYPC states: "Highly suicidal. He is experiencing auditory hallucinations which are telling him to kill himself. Believes other inmates are plotting to kill him. Spanish speaking only and illiterate. Highly agitated. Unable to differentiate reality from command hallucinations. Danger to Himself and Others; Dx: Atypical Psychosis." His chart reflects multiple suicide attempts, assaultiveness, and his 3/97 admission to CNYPC was for cutting himself with a razor and then swallowing it. This was his fourth admission to CNYPC, but first during the present prison term. While he was not cooperative with treatment, the staff at CNYPC felt he harmed himself in response to command hallucinations. He has been on and off the OMH caseload, he is prescribed Elavil at his request, he is not cooperative with treatment, he goes in and out of SHU and in and out of observation (i.e. he cycles between SHU and observation); he seems to be suffering from intermittent psychotic episodes with multiple suicide attempts. He has also been prescribed Trilafon (an anti-psychotic medication), Depacote (mood stabilizer), Benadryl, Zoloft, Thorazine, Vistaril and others. He has also been diagnosed Impulse Control Disorder. During a 5/7/03 fifth admission to CNYPC it is noted that he sexually assaulted a female MH worker in SHU (likely exposing himself, and he seems to have a proclivity to doing that), he is assaultive, and some questions are raised about the authenticity of his claims about auditory hallucinations. His discharge summary (5/27/03) diagnoses Impulse Control Disorder with Schizoaffective crossed off the list of diagnoses. He was in restraints, in observation, and on a SPF 1 Behavior Management Plan in the hospital. He was discharged back to SHU because the treatment team decided he was neither psychotic nor suicidal any longer – but they note that the psychiatrist at the SHU reported bizarre behavior and thought process.

In summary, this prisoner is intermittently psychotic and self-harming, carries many bona fide diagnoses, but also a management problem and is currently in SHU. Clearly his being in the SHU makes his mental illness flare up, and then he cycles to observation and/or CNYPC. At CNYPC, when he exhibits bad behavior, staff begin to think he is feigning psychosis. However, the psychosis seems to be real and ongoing, based on history, chart review and my mental status examination.

Example of:

Psychosis and Depression in SHU

SHU worsens symptoms

Undiagnosed by CNYPC

Cycle from SHU to observation with suicide attempts

O. N.

(Interviewed while housed in SHU).

O. N. had been in the SHU for one year when he was interviewed. He describes feeling very lonely and isolated in SHU, where he "goes into" himself, has nothing to do and gets bored, and then gets into trouble with neighbors or officers. He is

being treated for psychosis with Risperdal and Zyprexa. On mental status examination he exhibits loose associations, inappropriate and labile affect, he makes non-sense sounds, and is obviously internally preoccupied with auditory hallucinations. He exhibits clear First Rank Symptoms, including the belief that people are controlling him and getting him to believe certain things. In other words, he is quite obviously actively psychotic at the time of our interview. He complains of an inability to concentrate, and though he earned a GED in prison, he is unable to read in his cell in SHU, and this makes him distressed. He does not feel that the mental health staff take him or his problems seriously. He sees a psychiatrist once a month in an office.

A review of O.N. clinical chart reflects that he was in SHUs at various institutions since approximately October, 2001. His diagnosis on 3/29/01 was Depressive Disorder NOS, and on 1/30/02 it was Psychotic Disorder NOS. He has been at MH Level 2, 3 or 4 except he became a 1 on 6/20/02. A Screening/Admission Note in Groveland CF notes bizarre behavior. A Core History on 4/8/01 notes auditory hallucinations and setting fire to his cell, and a history of psychiatric care prior to incarceration and polysubstance abuse. He was in RCTP from 11/19/02 until 12/13/02, for threatening behavior and medication non-compliance (Rx Paxil 40 mg./day). A 5/17/02 review of treatment plan notes PIMS Level 1, "obsessional mind, tangential & circumstantial thought process, and he may need MH Level 1 services in future." A 9/26/00 progress note reflects a trial of Risperdal 2 mg. b.i.d., for Psychotic Dis NOS. On 11/24/01 he is in SHU, tossing property out of cell, which initiates a call for a psychiatric evaluation – he is noted to have messy cell and poor hygiene, but Dr. Abid Darr, M.D., sees him and diagnoses substance abuse but no psychosis nor depression; on 1/30/02 Dr. Darr decides his diagnosis is Psychotic Dis NOS, R/O Schiz, but he is still in SHU and refusing meds. A 4/5/02 notes a one month trial in double cell at Upstate, which was a failure because he should not be double-celled, and he is transferred from Upstate to Southport SHU. At Southport he remains at PIMS Level 1 (it is very likely he cannot progress because of his serious mental illness). He writes psychotic-appearing notes to judges and others. He continues to refuse medications, and continues to be confined in SHU. On 7/11/02 he is prescribed Zyprexa 10 mg./day plus Paxil 20. He continues in SHU, is on and off medications, outpatient "supportive therapy" is provided, mostly at cell-front. On 11/20/02 he is in observation on medications. He is still in observation on 12/1/02. He is sometimes diagnosed "no diagnosis, ASPD" on Axis II, he is given Mental Health Level 6 on many screenings in SHU, and then on 7/8/03, during his first admission to CNYPC for paranoid delusions and decompensation, his Diagnosis is definitely Psychotic Disorder NOS and he is prescribed Seroquel 800 mg. Per day, Trileptal, 600 mg. Per day, Clonidine .2 mg b.i.d., and Risperdal 2 mg. Per day. In other words, this admission disproves previous assertions he does not suffer from an Axis I serious mental illness, and his decompensation into an acute and severe psychotic state in SHU requires very high doses of anti-psychotic and antidepressant medications. At CNYPC he is noted to have a possible history of psychiatric treatment for severe mental illness from childhood; it is noted he has been frequently diagnosed Psychosis NOS within DOCS, has been prescribed several anti-psychotic meds including injections during years in DOC, and that he has deteriorated in SHU and has been a compliance problem.

In summary, this man suffers intermittently from psychosis and depression, remains in SHU with occasional trips to observation where he remains for weeks, is inconsistently prescribed antidepressant and anti-psychotic medications because he does not comply, is not sent to CNYPC and is never accused of malingering. Outpatient therapy in SHU mostly consists of monthly cell-front or office visits.

Example of:

Severe psychosis in SHU

SHU worsens psychosis

Un-diagnosis, on psych meds, subsequent breakdown disproves

Cycles from SHU to observation & CNYPC and back to SHU

Sent to Upstate/double cell in spite of SMI

O.E.:

(Interviewed while housed in SHU).

O.E. has been in prison for four years. He has been in SHU ever since he came through Downstate Reception. He says he has "poor communication" with SHU staff, and gets tickets. He is psychotic and takes Zyprexa. Prior to incarceration, he had been admitted to Bellevue's psychiatric ward two or three times, had been in the state psychiatric hospital and had been homeless. He is seen by Dr. Fontana monthly, at cell-front. He explains that because the officers plot against him, he does not take showers. He also talks to himself out loud and he tells me that the staff think he's crazy. On mental status examination, his affect is very flat, he gives off an odor from not bathing, and he talks about voices but prefers not to call them voices. He seems internally preoccupied with First Rank Symptoms and ideas of reference. I asked him if the voices have anything to do with his receiving tickets, and he said, "If they don't respect me, there's trouble." He was in the STP at Attica and liked the group therapy. He was discharged for outstanding charges, involving unhygienic acts. He has received tickets for self-harm. He complains he cannot get to see the doctor, he gets angry about the refusal of mental health staff to see him, and he either talks to himself or harms himself. He says he has been to observation quite a lot, but doesn't feel he needs to go to Marcy.

This prisoner's clinical chart confirms pre-incarceration multiple psychiatric hospitalizations, and a diagnosis of Schizo-Affective Disorder/Bipolar Type in 1999. He studied up until the fifth grade level and cannot read or write. Early OMH clinical notes diagnose PTSD. He has been in SHU most of the time he has served in prison. He is confined in SHU and periodically found to have hygiene problems with a foul smell emanating from his cell. He was in Attica STP in 6/00. Around that time he had no Axis I diagnosis, and an Axis II disorder. He was admitted to CNYPC for the first time on 3/20/03, for an overdose of Naproxen (a non-steroidal anti-inflammatory agent). He was also prescribed Vistaril and Zoloft. At CNYPC, Dr. Wilson did a Hare Psychopathy checklist evaluation and diagnosed ASPD. He was admitted to RCTP on 4/4/02 for "decompensation... pt. Collecting shit in cell has not showered X 1 month, yelling out. Admitted to RCTP on 12/11/02 "decompensating, voices, rapid speech, poor hygiene, hearing voices." Again on 7/1/03, he was admitted to RCTP for poor hygiene, paranoid,

fighting. Multiple SHU MH screens at cell-front note he is unhygienic, paranoid, refuses to talk, etc. Yet his diagnosis is sometimes either none on Axis I or Depressive Disorder without psychotic features. On 5/7/03 he was diagnosed Major Depressive Disorder without psychotic features. In Sept., 2003, there is a diagnosis of Adjustment Disorder with Depressed mood. His medications are mostly antidepressants, but on 11/23/02 he was prescribed Zyprexa, 5 mh., Celexa and Trazadone; in April, 2003, he is prescribed Seroquel 50 mg. at bedtime; and in May, 2003, he is prescribed Thorazine 50 mg. at bedtime. He is also periodically prescribed antidepressants. Many notes in his chart reflect psychosis and/or severely regressed depression – e.g. frequent mention of paranoid ideas, self-destructive, unkempt, unhygienic, lethargic. In summary, this man has spent much of his prison time in SHU, has been repeatedly suicidal and has been to CNYPC once and observation in the RCTP many times, each time returning to SHU. There is very strong evidence of intermittent psychosis, both in my mental status examination and in the narrative chart notes even when psychosis is not diagnosed, and there is the prescription of anti-psychotic medications along with antidepressants; however, since a psychological assessment in April, 2003 found only ASPD, his diagnosis has been downgraded and he has continued to cycle between observation and SHU.

Example of:

Psychosis in SHU

Disciplinary problems probably related to SMI

Un-diagnosed @ CNYPC by Dr. Wilson per Hare Test

Subsequent obvious psychotic episode(s)

Given antidepressant and anti-psychotic meds with no dx

Cycles from SHU to CNYPC & observation and back to SHU

Southport 3/12/03

F.O. (Interviewed by Drs. Kupers & Fulwiler & Betsy Sterling while housed in SHU).

F.O. told us he has a pre-incarceration history – hospitalization at Elmhurst Hospital in Queens – and his diagnosis is Schizophrenia. He says he sees things that are not there. He was in Protective Custody at Auburn, but got into trouble with an officer and was sent to SHU. He says he isolates himself at Southport for fear his anger will break out and he will get into more trouble. He admits to feeling paranoid, and says that he also isolates himself to protect himself from enemies. He thinks his confinement at Southport is “a test,” and his explanation of the test moves on to a discussion of voices. He believes “they are trying to inject me with HIV through their TB test.” He has made suicide attempts by slashing his wrists in prison. He sees the psychiatrist, but does not trust him. He is prescribed Atarax, Benadryl and Sinequan. He talks about the voices being from Satan. The voices try to manipulate him, and command

him to do things or tell him someone is going to hurt him. He gets angry or depressed in response to the voices. He stays up nights reading the Bible.

This prisoner's clinical chart contains a psychiatric evaluation in jail noting no MH problem, an admission diagnosis by OMH of Adj. Dis at 18 upon admission to DOCS. After a few weeks in GP, a social worker notes on 9/29/87 some psychotic-sounding symptoms about strange thoughts, notes that he is vague and evasive, and says he will follow him. On 1/6/98 malingering is noted. He is screened but not admitted to MHU on 1/6/99. His MH Level goes from a 6 on 2/7/00 to a 4 on 3/14/00 and a 3 on 4/5/00, all at Southport. Besides ASPD, he has an Axis II Diagnosis of Mental Retardation on 3/19/00. There is a diagnosis of Depressive Disorder on 4/1/00. He is admitted to the OMH caseload 4/26/00, having spent most of his prison time in SHU. He is assigned to outpatient treatment with monthly treatment plans as of late 01, early 02 – he is viewed as stable, PIMS Level III. A 4/9/01 note reflects “tangential and unfocused.” On 5/1/02, treatment plan review notes “He is generally cooperative with MH therapy sessions. He does, however, typically discuss issues that have no relevance to MH and emotional functioning. In the past, he has exhibited suspicious thought process, but in recent months not. He is currently not Rx'd psychotropic medications.” A 7/26/02 review notes: “still somewhat grandiose and tangential in thought process....” “services are limited due to restrictions of SHU.” 7/02 – 10/02 prescription of Zyprexa, Depakote. On 10/25/02, “He has refused to comply with recommended medication trial of Zyprexa and Depakote. From 1998 through 2000 there are a series of handwritten notes in chart from F.C. or another name, Ar-Rashid Al-Akbar, with clearly regressed, psychotic content. In summary, this chart is consistent with my mental status exam. Diagnoses vary, including Adjustment Disorder with Mixed Features, Depression NOS and Personality Disorder. By 1/24/03, notes reflect OMH opinion he is not suffering from mental illness but merely seeks transfer out of Southport SHU. There are other OMH notes implying malingering, but then on 8/17/02, a psychiatrist's progress note states: “Non-stop talk, disconnected, tangential, pseudo intellectual presentations, looseness of associations, psychomotor hyperactivity, grandiose.” Impression is Narcissism with Grandiose Delusions, and medications prescribed include Zyprexa and Depakote. (Zyprexa 10 mg. and Depakote 1000 mg were discontinued 10/12/02 because of non-compliance.) A 3/19/03 progress note by Bill Vertoske, a Psy II who does not believe he suffers from SMI, notes his reaction to our interview on 3/12/03, “He began session by telling us that we were ‘in trouble’ following his interview with clinical experts last week per current lawsuit.” This man is chronically psychotic, sometimes coherent and sometimes not, receives outpatient treatment in SHU with no admissions to CNYPC, and is intermittently declared not to be suffering from SMI, and then treated as if psychotic.

Example of:

First episode of psychosis after entering DOCS as a late teenager

Psychosis in SHU

Inadequate treatment

False ascription of malingering

H. N.

(Interviewed while housed in SHU).

H. N. has been in SHU since 1988 (at Clinton, Attica, and now for five months at Southport). He has been to CNYPC four times between 1991 and 2001. He is admitted to the psychiatric hospital because the voices he hears get out of control and command him to harm himself, often by banging his head against the wall. He states: "I've been in the SHU too long, to be honest with you, because I have mental health problems and instead of giving me mental health treatment they give me tickets." Most of his tickets, he reports, are for hurting himself. He has a history of psychiatric hospitalization in Hawaii in 1987, prior to his incarceration. He describes severe depression, including psychomotor retardation and vegetative signs. His last ticket was six months ago, and he has a sentence in "the box" until 2009. He also receives tickets for fighting, and he says that his depression causes him to fight – i.e., he cannot control his anger when he is depressed. He takes Haldol, Elavil and Benadryl. He says OMH does not help him because of the fights he has been in – one occurred while he was at CNYPC. He cannot read or write. He says, "I be bugging out in my cell, I talk to myself, I make up things, I listen to radio, I think a lot about bad things, I hear voices at night, I get depressed, I pace, sometimes for hours, I feel like the walls are closing in on me, I get really nervous and I jump out of bed." He has been rejected for admission to the STP. On his clinical chart there is a diagnosis of Major Depression with Psychotic Features during an admission to CNYPC in October, 1998, and again in December, 2002, and a note documenting the hoarding of feces during an admission to RCTP on 9/27/99. He seems to have entered DOCS around 1990, with violent assaults on his record. He had seen a psychiatrist for five years as a child and he was prescribed psych. medications, although he didn't know which ones. His diagnosis in 1990 was Adjustment Disorder, but since approximately 1996, it has been Major Depressive Disorder with Psychotic Features. He is both very assaultive and repeatedly self-harming, with multiple cuts on his own body. He has been prescribed Haldol and Cogentin, at other times Zoloft and Risperdal. His thick chart contains notes about banging his head on bars to the point of bleeding, many stays in observation when he did not eat or acted inappropriately, etc.

Example of:

Psychosis/depression in SHU

Inadequate treatment

Describes mental problems leading to tickets and time in SHU

D.P.S. (Interviewed while housed in SHU).

D.P.S. has been in prison for six years of a 25 to 50 years prison term. He has been at Southport for two months, but in SHU since 2001, and he will be released from SHU in 2004. At Five Points he was on the OMH caseload, but he says he did not want to take psychiatric medications, so he was sent to Southport. He has been told he suffers from Bipolar Disorder. He knows he gets very depressed. He was on Depacote, but did not want to take it because of side effects. He has not attempted suicide. He says there are no mental health services at Southport. He cannot explain why he is currently in SHU. He had a lot of problems with a bunkie while he was at Upstate. When he was in population, he did fine. He was investigated for gang affiliation while at Five Points. He tells me he leans toward the Egyptian culture, maybe the race. He found Clinton to be a much worse SHU than Southport, and Clinton a rougher prison. He does not go to the recreation area; he says "they won't let me because my hair is too long." He seems depressed on mental status, with psychomotor retardation and a sense of hopelessness. He says he does not want to take medications "on principle."

Example of:

SMI in SHU – he reports Bipolar Dx

Not on treatment – discontinued because of non-compliance

A.Q. (Interviewed while housed in SHU).

A.Q. has been in prison for five years, and he has been in SHU for four years. He says he gets out of SHU next month. He believes the officers mess with the food. At Upstate they put a bigger guy in the cell with him. There were no witnesses (my assumption is that violence occurred – he doesn't want to talk about it). In October, 2002, he was on a 1-to-1 watch, but usually, when he asks for mental health help, none is forthcoming. He requested STP at Five Points, but was refused because they said he does not have enough box time. He believes his tickets are usually on account of his mental illness. He cannot handle the stress when he is double-bunked. He gets very depressed in SHU. In September, 2002, there was a family tragedy (he lost his father and a child), and then he wrote a suicide letter himself. He complains that nobody from OMH came to see him. He feels he needs someone to talk to. He sees "the psych" once a month for 15 minutes. He is depressed most of the time, "down on myself"; his only pleasure is in hearing good things about his children. He has been taking psychiatric medications since he left Reception. On mental status examination he is very depressed with obvious internal preoccupations.

Mr. R.A.'s clinical chart documents a diagnosis of Psychotic Disorder NOS on 9/25/01. There was a suicide attempt on 12/28/01. There was an admission to CNYPC from Five Points SHU – observation in May/June, 2002, for depression and suicide ideation with auditory hallucinations, Diagnosis Psychotic Dis NOS or Depressive Dis NOS, Rx Zyprexa 20 mg./day, Lamictal 100 b.i.d., Prozac 20 mg. upon admission. A 6/5/02 Trauma Screening Form reflects molestation by priest at age 13, and reported death of twin brother – but interviewer felt he was fabricating “some facts.” At CNYPC staff notes malingering, vs. “seeing things,” “hearing things.” Mother’s story conflicted with his. Discharged with Diagnosis Dysthymic Disorder, with suggestion his hallucinations are not authentic. A 7/23/02 Core Outpt. Eval. suggests malingering, and he is in SHU at Five Points. A 7/1/02 progress note in observation at Five Points, after he has been there for ten days due to “concerns regarding lethality,” states he feels better and does not want to return to CNYPC. On 7/8/02 he is told he does not qualify for STP because it’s for inmates with ‘severe and persistent mental illness.’ He is seen cellside in SHU every two weeks for a while. He is changed to a MH Level 2 on 8/26/02 so that he can be double-bunked. He was on no psych meds after discharge from CNYPC (D/C order on 6/25/02) and is discharged from OMH services on 8/26/02. A 9/24/02 Outpatient Screening Note reflects that his father, sister and daughter were killed in a fire in No. Carolina. He was re-admitted to OMH caseload with a diagnosis of Acute Stress Disorder, no meds. On 9/30/02 he was re-admitted to observation at Elmira on 1-to-1 watch. Rx Vistaril 100 mg. b.i.d. He remains in observation through 10/7/02, then returned to SHU at Southport. He expresses wish to work on sexual abuse issues and complains that nobody from MH listens to him. He was seen every couple of months for FU, and in 90 day MH screens in SHU. On 1/7/03, a Treatment Plan Review notes no medications, PIMS Level II, no self-harm, soon to be released from SHU. In summary, this young man with no prior psychiatric history is in SHU for a lengthy term, suffers depressive and psychotic symptoms, is admitted to CNYPC, where it is then decided he does not need psych services, and then returned to observation and suicide watch. He had prescriptions for Zyprexa and antidepressant, but later, in observation, he is given Vistaril. He is taken off and put back on the OMH caseload. Obviously, he experiences great difficulty managing in the SHU.

Problem:

SMI in SHU

Un-diagnosis

Discontinue because OMH believes malingering

S. V.

(Interviewed while housed in SHU).

S. V. believes that the Attorney General is manipulating his mind and getting him into trouble. He sees an OMH therapist but takes no medications. He was at ICP at Attica in 1993-1994. He is Hepatitis C positive and believes he got the disease from the food. On mental status he exhibits loose associations and quite obvious delusional material. He also exhibits intense anxiety and pressured speech. He is acutely delusional

and quite disturbed. He claims he is repeatedly assaulted by staff because he does not back out of his cell correctly. He is obviously actively psychotic.

Example of:

Psychosis in SHU

Not adequately treated

Five Points Correctional Institution – 3/13/03

B.Y.

(interviewed while housed in observation).

B.Y. is seen in observation, where he was transferred from SHU. He has been in prison for 16 years. He is taking medications for hypertension, has had strokes, and has had triple bypass surgery. He calls the medical unit, "Walsh" (the regional medical unit, where he was probably on Keeplock) a "Death Unit," and says you only go there to die. He has been in the box for five months, and being thus confined has made him very depressed. When asked why he is in observation, he responds "they are playing with my food." When the therapist, Ms. Miller, came to see him at cell-front, he threatened to harm himself. On mental status examination, this man is quite depressed with psychomotor retardation and an intense sense of hopelessness. He reports uncontrollable anger and paranoia, feels bitter, cries quite a lot and experiences lethargy. His clinical chart is consistent with the history he presents. He has been at Walsh, and on 8/21/01 was transferred from there to the RMU and on to Five Points OMH Satellite Unit. He is diagnosed Mood Disorder Due to Gen'l Medical Condition, Alcohol Dependence, Impulse Control Disorder (he has many tickets, some for assaults), Personality Disorder and medical conditions including Asthma, Hypertension, Seizures, etc. He has a pre-incarceration psychiatric history, a weekend admission to Bellevue at 16 or 17, but he was involved with substance abuse at the time. There is a history of sexual abuse from childhood. Meds included Risperdal 1 mg. per day on 9/28/01 plus assorted medications for physical ailments, including Atenolol 75 mg. b.i.d. and Dilantic 200 mg. b.i.d. On 1/17/02 he was taking Seroquel 200 mg. per day. He has been admitted to Satellite Mental Health on at least four occasions for suicide prevention, and has been followed as an outpatient by OMH with monthly contact while in SHU, but he has not been admitted to CNYPC. At Five Points, on 1/31/02, upon admission to Satellite Unit for suicide risk, it is noted he wants to be returned to RMU (Reg'l Medical Unit) and has difficulty having a younger cell mate in a SHU setting. He evidently yells on the SHU gallery, bangs on his cell door, etc. He explains it is an attempt to have himself transferred to a RMU where his medical conditions can be treated.

Example of:
Depression and likely psychosis in SHU
Severe medical condition
Deteriorates in SHU

D.G.

(Interviewed while housed in observation).

D.G. has been in prison for many years. He jumped from a 4th floor at age 20 – he says he sincerely believed he could fly. Between prison terms in approximately 1996, he was civilly committed to Mid-Hudson, where a fight occurred and he reports he “killed a roommate.” He re-entered DOCS in 1997, and he says, he is considered mentally ill and dangerous. He has been to CNYPC, where he was told (following a psychological assessment by Dr. Wilson) that there’s nothing wrong with him, “it’s a behavior problem.” He complains the staff threaten him. He has been in observation for 56 days. He received his clothes and letters a few days prior to our interview, but before that he was stripped and lacked amenities. When asked if he suffers from a mental illness, he reports he has been depressed since age 15 or 16. He attempted suicide at 15 or 16 and was admitted to a psychiatric hospital (Marcy as civil commit?) There he was charged with assaulting a staff member in 1989. He says he gets depressed a lot, he will not admit to hearing voices, but “something” tells him “to do certain things.” He was admitted to Mid-Hudson three times on civil commitments or court-related evaluations. In 1988 he attempted to hang himself in jail and was admitted to CNYPC for a competency evaluation. He remembers he had been on street drugs, was very paranoid, and the jail officers thought he was a threat to the jail. He thinks the officers mess with him and hold back his meals. He has set cell fires within DOCS. He has tried to hang himself and he has cut his wrists. He claims he did not brush his teeth for 30 days in observation because he had no tooth brush nor paste. He has never been in SHU. He was in ICP and did well at Wende. He has been prescribed Thorazine, Stelazine, Seroquel (400 mg. twice a day) and Depacote (1000 mg.). The anti-psychotics did help him calm down, and Depacote helped stabilize his moods. He has tried Prozac, but became agitated. He says his only interviews with mental health staff occur at cell-front. He has received tickets for threatening staff, but these incidents only occur after his medications are discontinued. He wants to be prescribed the medications. On mental status he seems depressed with an edge of agitation. He has ideas of reference, believing that the C.O.s mess with him and refuse to give him his meals. He has “thoughts” (his euphemism for auditory hallucinations) that he believes are really people trying to make him do things. He describes a feeling that he is going crazy, “my brain feels like it’s blowing up.” He reports that when he feels like threatening people, he punches himself in the face instead, or bangs his head against the wall. He complains of severe anhedonia.

D.G. thick clinical chart fills two cartons. There is corroboration of much of the history he presents. He has spent most of his adult life in a mental hospital or behind bars. He is serving a life sentence. A car accident in 1976 led to a seizure disorder. During his first DOC bit, around 1995, he cut himself repeatedly and had to be hospitalized. He cycled to Observation quite a lot, was prescribed high dosages of mood-

stabilizing medications and anti-seizure meds. He soon was treated with anti-psychotics as well, and intermittently with antidepressants. He continued recycling to Observation, CNYPC and back to GP or Keeplock. He was convicted of killing a roommate at Mid-Hudson Psych. Center on 7/30/98 by choking. He is consistently noted to get agitated, engage in "para-suicidal behavior" and represent a grave danger of assault as well as self-harm. He is usually MH Level I when in Observation or CNYPC. He was functioning well in ICP in October, 2001, with diagnosis Adjustment Dis w Depressed Mood, and a combination of mood-stabilizing, antidepressant and anti-psychotic medications. During a 9/18/01 admission to 5-Points OMH Satellite his diagnosis was Organic Mood Disorder, Mixed, with Vistaril and Thorazine prescribed. During his 43rd admission to CNYPC in August, 2001, he complained of agitation and auditory hallucinations commanding him to kill others. He was prescribed Seroquel 800 mg. per day, Risperdal 6 mg. per day, Remeron 45 mg. before bedtime, Vistaril 300 mg. per day and Phenobarb 60 mg. b.i.d. On 10/01/01 his diagnosis was Intermittent Explosive Disorder with ASPD and Seizure Disorder. He was discharged to Wende ICP, but he had homicidal feelings towards a reputed child molester and had to be sent back to CNYPC. An 11/21/01 report of Neuropsych. Testing by two Binghamton University students found that P.G. has deficiencies in multiple realms, including intellectual functioning, memory, and self-harming behaviors. He was admitted to CNYPC for the 47th time on 3/1/02, with diagnoses Impulse Control Dis. NOS and ASPD, because he tried to hang himself after acting "agitated." He was found on the floor with a noose around his neck and had to be sent to the medical hospital. He was prescribed Remeron 30 mg., Depacote 2,000 mg., Seroquel 600 mg. and phenobarb 90 mg. at time of admission. He was noted to calm down and act appropriately at CNYPC, except he got into disputes with other inmates and had to be placed on a SPL I because he was suicidal. He was intermittently placed in side rooms or in 5-point restraints, often for agitation, and was given injections of neuroleptics on an emergency basis several times. He was noted to suffer seizures, for which medications were prescribed. Upon discharge on 3/15/02, he is calm, but is "guarded and suspicious." He is seen as goal-directed and manipulative, with ASPD and Borderline Character Disorder. He is prescribed Depacote 1,000 mg. b.i.d. and Phenobarb 90 mg. b.i.d. On 9/13/02 he was re-admitted to CNYPC because he made a serious suicide attempt by hanging and was cyanotic, plus he was banging his head. A "Behavior Plan for P.G." is dated 1/09/03. In it, a PCL-R score of 40 (out of 40) is noted, it is noted he has spent nearly 50% of his time in DOC as a psychiatric inpatient, and a series of consequences are outlined. He will not be re-admitted to CNYPC (too much secondary gain and no benefit), he will be placed in observation with minimal amenities (two mats and a smock) and a 1-on-1 DOC watch when he is self-destructive or assaultive, There will be a weekly teleconference about him with CNYPC and 5-Point treatment teams, each time he acts out he will be made to participate in a "careful behavioral chain analysis, he will be subject to usual DOC disciplinary procedures, he will be medicated symptomatically, he will be praised for good behavior, when he demonstrates appropriate behavior for five days he will be given further amenities, a job possibility will be sought when he is on good behavior, and he will not be admitted to ICP or STP (for which he is ineligible), but since he cannot be in GP he will be sent to Administrative Protective Custody with constant video surveillance. It is

anticipated he will display a protracted increase in self-injurious behaviors, termed an "extinction burst," after this plan is instituted. This behavior plan is supported by a 11/18/02, 112 page Psychological Assessment by Dr. John S. Wilson, in which ^{P.G.} history is summarized; he is given no Axis I diagnosis but Axis II diagnoses include ASPD (psychopath), narcissistic and sadistic personality disorder, and it is noted he does not even meet the criteria for Borderline Personality Disorder, but his instability of mood make psychotropic medications likely helpful, etc.

Subsequent to the Behavior Management Plan (1/9/03): He was in Five Points OMH Satellite Unit from 1/15/03 until at least 4/14/03. There are daily, brief typed notes while he is in observation with gown, blankets, no mattress – notes mostly comment about whether he is eating. Clearly he gets no recreation. He is treated with Haldol or Seroquel to "help with his temper." His medications are discontinued because he does not suffer from mental illness. He has a JMC (Joint Management Committee). Dr. Wilson comes to visit from CNYPC and alters the management plan; ^{P.G.} gets his "greens" (clothes?) back in late February, but not full amenities. He is given CBT daily for fifteen minutes, but seems uncooperative – notes reflect he does not wish to participate in skill-building, etc. Given full amenities, but in observation cell, on 3-12/03. Communicates re sex with other P in RCTP by writing in a novel and passing it to the other. Notes go through 4/14/03, he is still on 1-to-1 observation in RCTP, still in smock and mats, still threatening suicide with very limited amenities. By 5/14/03 he remains in observation, is on loaf for throwing milk, and is on random 15 minute checks instead of 1-on-1. He is not on medications, but is requesting them. He intermittently refuses to eat for significant periods of time. By 6/2/03, he has had a hearing for two tier 3 tickets (including throwing milk at CO while in observation), and is given six months SHU time, which he will serve in the STP Unit, but he will not be in STP programming. He was placed on A2 Unit, and told staff he liked SHU better than observation, and enjoyed rec as well as keeping food in his cell. A few weeks later he was given a razor. He had additional hearings and was given more SHU time. He adjusted well to SHU until he "cut up" on 7/11/03, and was sent to outside hospital where 60 stitches were done on his arm, and then he was returned to 1-to-1 observation in RCTP. His behavior deteriorated, he smeared feces and rubbed feces in his wound and picked at sutures. He was placed on loaf, and again began refusing to eat. As of 7/22/03 he is in RCTP, non-cooperating with CBT, on a self-harm hunger strike, and on 1-to-1 watch and video monitoring, with limited amenities. Notes continue through 7/30/03 that describe how he is still in observation on 1-to-1, but he is eating.

Example of:

Probable atypical SMI, with depression

Most of time spent in isolation, SHU or observation

Self-destructive over entire lifetime

Un-diagnosed and put on Behav Mgmnt Plan

Remains on anti-psychotic & mood stabilizing meds even after un-diagnosed

Spends very long time in observation w no amenities

Probably regresses in SHU
Many, many admissions to CNYPC

T.Y.

(Interviewed while housed in STP).

This is T.Y.'s third prison term. He has been in STP since Dec. 5, and he has been in SHU since 2001. He likes STP better than SHU because there are more opportunities to talk to staff. He likes group therapy and the movies that are shown. Two weeks prior to our interview he had an incident in which he blacked out and felt his mind was not right, but the COs who took him to the infirmary joked about his situation. He was 16 when he was involved in "the riot" at Southport, and feels the staff never lets him forget that. He is taking Prozac, Risperdal and Seroquel, and feels the medications slow his speeding mind and help him sleep. Still, he keeps believing they are poisoning his food. He has a very difficult time in SHU, the noise bothers him, he cannot quiet his racing mind. The last of several times he was at CNYPC was last November, after staff discontinued his medications because they found pills in his cell that did not belong to him. He hears voices commanding him to cut himself. When he cuts his wrists the officers disrespect him, he is taken to observation where there is no mattress and no sink and he is stripped and his voices get worse. He has heard voices since childhood, but never as bad as when he is in SHU. He was shot in the lungs as a teen, and attempted suicide as a teen, and was taking psychiatric medications prior to coming to prison. He abused substances. He has "panic attacks" in the SHU. He believes the COs harass him as "get back" because of the 1991 "riot." He complains the COs beat him for no reason. His symptoms and history are very credible, and he suffers from psychosis with or without a mood disorder.

The clinical chart for this prisoner reflects MH Level 1 since January, 2003, at least four admissions to CNYPC since 1998, and that he has been diagnosed Schizophrenic, disorganized type, and has been observed to have bizarre, sometimes catatonic behavior. He was transferred from Auburn SHU to CNYPC on 11/16/01, was clearly psychotic and regressed with a Dx. of Schizophrenia, and back to Auburn SHU at discharge on 4/18/02. He was treated with anti-psychotic medications, including Seroquel 250 mg. per day, and was noted to be very regressed. Previous admissions to CNYPC included self-harm, once by hanging. A 12/5/02 CNYPC discharge summary notes a recommendation that Prisoner M.M. go to STP, and that recommendation was followed. This very disturbed man with Schizophrenia decompensates intermittently, but he is also assaultive and draws long SHU terms – there is no evidence on the clinical chart that MH staff intervene with hearing officers. He receives many tickets which result in increased time in SHU, and the dates of the tickets are interspersed between admissions to CNYPC. Time in SHU worsens his psychosis. STP is an improvement, but he should not be returned to SHU and needs a longterm treatment setting such as ICP.

Example of:
Severe psychosis, Schizophrenia, in SHU
Symptoms worse in SHU

Cycling from SHU to CNYPC and observation & back to SHU
Tickets related to mental illness
Recent transfer to STP – concern re future return to SHU

Sullivan Correctional Institution – 5/5/03

D. V. J.

(Interviewed while housed in the Satellite Unit).

D. V. J. had been at Fishkill until one year earlier, when he was transferred to the MH Satellite Unit ICP. There he took prescribed psychotropic medications (the anti-psychotic Zyprexa) and managed adequately until mid-April, 2003, when he stopped taking his medications. His behavior regressed, and he began to threaten others and became agitated and disorganized. He was about to be transferred to CNYPC when we met. On mental status exam, **D. V. J.** was agitated, with pressured speech and loose associations, and spoke passionately in a sometimes delusional manner, while at other times seeming lucid and concerned about very real dangers facing him in the prison environment. He told us he has never been to SHU, and feels that he has generally been treated alright by OMH. It is noted that **D. V. J.** was admitted to psychiatric hospitals prior to incarceration, he entered prison in 1994, and he is noted to have been suffering from Paranoid Schizophrenia since early adulthood. He has been admitted to CNYPC on multiple occasions (approx four times), usually due to non-compliance with prescribed anti-psychotic medications (Risperdal, Zyprexa).

Prisoner

B. B. C.

(Interviewed while housed in observation).

B. B. C. was transferred from nearby Woodburn Correctional Institution to the Satellite MH Unit because he told an officer he wanted to hurt himself. He states he is Bipolar and takes Depacote, Benadryl, Risperdal, Zoloft and Haldol. He has been hearing voices since 1999. He was hospitalized on a psychiatric ward at Bonseguors Hospital psychiatric unit prior to incarceration. He sees a psychotherapist at Woodburn, but feels it isn't really treatment because his therapist sees him only for a few minutes at a time and really does not wish to talk to him about anything. He stays to himself most of the time, and has a job as a porter. He has been in the ASAT drug treatment program and the ART anger management program. In observation he wears only a Ferguson gown and has only a Ferguson blanket and thin mattress in the cell with him. He has been in observation for approximately a week, and being here has made him even more depressed because there is nothing to do. He finished the ninth grade. He has never been in keeplock nor SHU. He feels that Woodburne is a "pretty OK place." On mental status examination he seems oriented in all spheres, his affect is flat with some depressed mood and occasional internal preoccupation linked to inappropriate laughter. Review of his chart corroborates his history and is consistent with mental status today. He had psychiatric treatment prior to incarceration; he made a serious suicide attempt in 1994, he is serving one and a half to three and a half years, and he has not been to CNYPC. He was transferred from Woodbourne to Sullivan MHU on 4/29/03 because of suicidal

ideation and plan. His Diagnoses include Bipolar Disorder and Paranoid Schizophrenia, and he is prescribed Risperdal 6mg./ day, Haldol 5 mg. pm, Depacote 1,000 mg, and Zoloft. He is MH Level 1. His history includes many suicide attempts while incarcerated. Later progress notes reflect diagnoses Par. Schiz and Bipolar, and he is treated with anti-psychotic and mood-stabilizing medications.

Example of:

Prisoner with SMI in Medium, no SHU time

Transfer to Max MHU when he decompensates

Kept in observation for a week without admit to CNYPC

Observation has harsh conditions

T.H.

(Interviewed while housed in SHU).

T.H. has been in prison for seven years on this bit, and had a prior bit of six years. He is mentally ill, HIV+, and has a serious drug problem. He has been in and out of SHU since 1998, mostly related to drug use within prison. He is not assaultive, but he has been in the same cell in SHU for two years, with seven months remaining of his SHU term. He would like to be transferred to Keeplock where he might serve out his SHU term while being able to attend drug treatment. He describes very severe depression, great trouble getting up in the morning and getting started with his day, a strong need to isolate himself even within the SHU context, and suicidal thoughts. He has been at CNYPC three times. He is proud of earning a "violence certificate" at Marcy. In SHU he is unable to concentrate and read, he has panic attacks, and the depression is much worse. He sees the psychiatrist approximately once a month at cell-front, but never has a private, confidential interview and does not really talk to the mental health staff when they make rounds at cell-front. He has been to the Mental Health Unit (observation) several times, the last time in December, 2002. On mental status he appears earnest but depressed. There is psychomotor retardation, a sense of hopelessness and low self-esteem. He says he is not currently suicidal because he has a plan to get himself placed in keeplock so he can be in drug treatment (he has not been in drug treatment except for a brief time in an NA program) and maybe earn his parole. His clinical chart corroborates his history. He was admitted to CNYPC in Aug. 2001 and again in August 2002. His diagnoses include Major Depressive Disorder with Psychotic Features, Psychosis NOS and Dysthymic Disorder. He has had many admissions to observation for suicidal behaviors, including hanging up and cutting himself. His emotional symptoms are clearly worse when he is in SHU. A 6/6/01 Admission Note to CNYPC gives reason for admission: "**T.H.** was referred due to regressed and unpredictable behavior. He was eating his own feces and was experiencing command hallucinations. He attempted to hang up in SHU and had to be cut down." His medications have included Thorazine 150 mg. h.s., Wellbutrin, Vistaril. Clearly this man suffers from serious mental illness, a severe mood disorder and psychosis, and he decompensates and becomes suicidal repeatedly while in SHU. He cycles from SHU to RCTP and CNYPC and back to SHU; he has a substance abuse problem and using drugs gets him sent to SHU and also worsens his mental illness. Yet he remains in SHU. He

needs to be removed and placed in a treatment setting such as ICP, and he needs concurrent substance abuse treatment.

Example of:

Depression with psychosis in SHU for substance infractions

Dual Diagnosis with Substance Abuse and SMI

Unable to get drug treatment because he is in SHU for drug offenses

Cycles from SHU to observation and CNYPC and back to SHU

Deterioration in SHU

Prisoner

G. G. A.

(Interviewed while housed in SHU).

G. G. A. smiles readily and says innocently "some of my disciplinary problems are because of my mental illness." He receives many tier 3 tickets because he writes threatening letters. The letter-writing is entirely compulsive, he explains, and he does not really think about it and he cannot stop himself. I asked if the compulsion to write threatening letters was related to mounting anxiety or anger, and he seemed reassured that he was being understood. I asked about earlier obsessive and compulsive symptoms and he averred washing his hands hundreds of times per day at age 13. He began making threatening phone calls in his mid-teens, and that became a habit. He saw a psychiatrist in the community who prescribed Zoloft 150 mg./day to help him cut down on the compulsive behavior. He was in the ICP, but two weeks ago he was charged with assaulting an officer – his first overtly assaultive charge although there have been many threats and threatening letters. He explains that he did not actually assault anyone. He is very hard of hearing, and did not hear an order to move back while being escorted and in handcuffs. He stepped back and lost his balance, and evidently bumped into an officer. He was accused of kicking the officer, was thrown against a wall and beaten. Since he has been in SHU the past two weeks he has felt much more anxious and has trouble controlling his "cussing." He also gets very depressed. He has not been admitted to CNYPC, but he does intermittently feel hopeless and suicidal. He cannot concentrate in SHU, cannot read, and has great difficulty sleeping. On mental status he appears quite sad in spite of his smiling, seems quite sincere, describes compulsions that include the writing of threatening letters, clearly has no intention of harming anyone, and seems perplexed about how he has gotten himself in the jam he is in and what he might do to get out of it. In other words, he seems quite innocent in multiple senses of that word.

The clinical chart for Prisoner ~~99A~~ confirms the history he presents. He has not been admitted to CNYPC. He entered Downstate Reception a MH Level 2 on 3/1/99, and his MH Level was changed to 1 at Sullivan on 10/21/02. His Dx is Obsessive-Compulsive Disorder and Depressive Disorder. He had one psychiatric hospital stay in the community, court-ordered for evaluation at time of trial. He was sentenced for "bomb threats." He has been prescribed Zoloft by OMH, and is described as a "shy, coy, childlike male who gets angry and makes false statements." (5/8/00). He has been seen by outpatient OMH staff, and has spent much time in SHU. There are no notations re OMH staff discussing his mental illness with any hearing officer, except on 2/22/99 a

note refers to referral to MH from ~~F.F.Z.~~ for second opinion – possibly regarding a hearing? There are many outpatient Progress Notes, mostly noting OK adjustment when he is in SHU (and seen at cell-front). He is sometimes in Protective Custody. He is prescribed 150 mg. Zoloft per day, plus Vistaril and occasional other medications. Nobody writes that they suspect malingering or doubt his diagnosis, until social worker David Privett writes on 11/20/03, that compulsion to write threatening letters occurs when angry, and therefore he doubts the diagnosis of OCD – this is an erroneous conclusion, since a compulsive symptom is likely to be worsened by anger or anxiety. Notes continue through 4/04. A psychiatric evaluation on 2/18/04 contains a diagnosis of Depressive Disorder + R/O OCD, and Zoloft 200 mg./day + Buspar & Vistaril is continued. He is seen cell-side frequently, and every two weeks by a therapist, cell-side or in a private room.

Example of:

SMI in SHU

Rule-breaking (threats) driven by SMI (OCD + Depression)

More disturbed in SHU

C.C.T.

(Interviewed while housed in SHU).

C.C.T. has been in prison for five years and has been in the SHU for one year. Before that he was in IPC (involuntary protective custody) because staff were afraid there would be retaliation against him for talking to investigators in a case involving the rape of his sister, where the perpetrator is also behind bars. He is depressed, and he cuts himself frequently. Last Thanksgiving he swallowed 40 or 50 pills in a suicide attempt. He receives disciplinary reports (tickets) when he tells the mental health staff on their rounds in SHU that he is contemplating suicide. He believes the officers are poisoning his food. He was seeing a psychiatrist in the community prior to incarceration, and taking Thorazine and Elavil. He is currently prescribed Zoloft. He has never been removed from his cell to see the mental health staff, rather he sees them at cell-front when they make rounds. When he was taken to observation following his suicide attempt last Thanksgiving, he ate his own feces because he very much wanted to die. He received a ticket for that behavior. He reports that being in SHU makes his depression much worse, and makes it impossible for him to get help from mental health staff. Currently he wants to die and is contemplating suicide. He feels hopeless about getting help from mental health while in SHU. He is overtly depressed, agitated, and anxious, and exhibits pressured speech and flight of ideas. His clinical chart includes diagnoses of no diagnosis, anxiety, depression, psychosis NOS and psychopathy, but also corroborates his story about repeated admissions to observation for suicidal behavior. A 7/21/03 inpatient CNYPC Screening/Admission Note has the diagnosis Psychotic Disorder NOS and ASPD, notes hallucinations and delusions as well as suicidal, mentions paranoia, and gives him a GAF of 25, with 60 the highest in the last year. He had been in observation at RCTP for a suicide attempt. The 7/21/03 core history notes no pre-incarceration history of psychiatric treatment. A Psychological Evaluation Notes psychopathy on the PCL-R. Psychologist John Pelkey recommends: "Any acts of self-harm or involvement

in para-suicidal activity should be viewed as entirely manipulative in nature." A Behavioral Management Plan is recommended. He is placed on SPLI Level 1. He was discharged from CNYPC on 8/12/03, on no medications. But on 8/07/03, he had been taking Risperdal 3 mg. per day and Zoloft 100 mg. per day.

Example of:

Severe Depression in SHU

Cell-front only treatment

Cycling from SHU to observation and CNYPC and back to SHU

Un-diagnosis

Remains on psychiatric medications after undiagnosed

Z. A.

(Interviewed while housed in SNU).

Z. A. has been in prison since 1987 and has been in the Special Needs Unit at Sullivan for the past year. He has been in ICP programs as well as General Population at several different institutions. He takes psychiatric medications, and reports that if he does not take the medications he will certainly hear voices commanding him to kill himself. He has not attempted suicide for several years, but earlier he was admitted to CNYPC. He is afraid of being sent to observation in the MHU because he had a very traumatic experience there. The last time he was there there was blood all over the cell he was placed in, and spiders and other bugs under the mattress and along the walls. Also, nobody talks to you. He spent a month there, naked except a thin gown. He gets tickets when he admits to being suicidal. Currently he is on Keeplock status for arguing with an officer while being transported to court. He has learned to read and write in prison, and now has a job. He has had multiple suicide attempts, including attempts to swallow batteries and razors. He has been called a malingerer in the past, but currently feels he is doing OK if he takes his medications. His clinical chart corroborates the history he presents. He has been admitted to CNYPC several times over many years. He is diagnosed Major Depression, Recurrent, with ASPD. Other notes include Psychotic Features, and command hallucinations are noted repeatedly, especially as involved in suicidal threats and behaviors that lead to re-admission to CNYPC. He has spent time at Meryl Cooper. He is prescribed relatively high dosages of anti-psychotic medications. Other medications at various times include Seroquel, Depacote, Neurontin, Remeron, Sinequan and various minor tranquilizers. Interestingly, in 1991, he was viewed as suffering from SMI, but his medications were minor tranquilizers, then antidepressants were added, and by 1994 or 1995, he was being prescribed anti-psychotic medications. One wonders if the stresses and traumas of prison life worsened his depressive condition and caused the psychotic features. There seems to be no disagreement that he suffers from serious mental illness and low intellectual functioning, even if IQ reported is 87, and there are notes about him not being appropriate for SHU.

Example of:

Psychosis/Depression and Mental Retardation

**Spent a month naked in observation
Viewed as not appropriate for SHU**

L. V.

(Interviewed while housed in ICP).

L. V. who speaks slowly, has been in ICP at Sullivan for a year. He has been in ICP, SHU, and observation at several institutions. He has been to CNYPC 19 times altogether, during his three prison terms. He reports he hears voices and gets very depressed. The last time he was discharged from CNYPC it was recommended he go to ICP. He has received tickets for assaulting an officer. He likes the ICP at Sullivan, and feels he is treated OK. His clinical chart corroborates his history. He was admitted to ICP on 8/9/02, was diagnosed Bipolar Disorder, and was prescribed Depakene 1000 mg. b.i.d., Risperdal 3 mg. b.i.d., and Zoloft 100 mg. His chart reflects a history of long-term serious mental illness from early adulthood with prominent auditory hallucinations, as well as a record of criminal behavior and assaultiveness. He becomes withdrawn, disheveled, suicidal, mute, smears his cell with feces when he stops taking his medication. He can also become assaultive, and has a long criminal record and many disciplinarys in DOCS. This man is in ICP, which is appropriate. He needs long-term mental health care and is obviously incapable of programming in GP and should never be in SHU. There are notes reflecting old head injuries/ organic brain disorder, and he did have some psych assessment in the mid-1990's, or a partial work-up. He seems to be erroneously diagnosed as Bipolar alone – he clearly becomes psychotic (some notes reflect psychosis, e.g. Admission/Screening form dated 8/9/00 – others do not mention psychosis) and is taking anti-psychotic medications as well as a mood stabilizer and antidepressant. Clearly, his condition worsened in SHU, and there is a question whether the ticketed behaviors that landed him in SHU might have been driven by mental illness. As of progress note dated 8/27/03, he remains in ICP, is prescribed Risperdal, Zoloft, Benadryl and Depacote, is working as a porter and waiting to be admitted to RSAT.

Example of:

Psychosis and Depression in ICP

Wrong diagnosis on chart: leave out psychosis

But prescribed anti-psychotic medications

E. P.

(Interviewed while housed in ICP).

E. P. is in the eighth year of his first prison term. He has been in ICP for one week, and prior to that he spent 45 days double-celled in general population, even though he is Mental Health Level 1. He has never been in SHU, but he has been in Keeplock and he has been in "a strip cell" (observation) many times. He has been suicidal on many occasions. He explains that if he does not take his medications he gets frustrated and "hangs up." He hears voices. Because he has Hepatitis C, he does not want to take an antidepressant. So he takes Risperdal, which helps "a little." He keeps his frequent suicidal thoughts to himself because he is terrified he might be sent to a strip cell again. His mental status reflects depression with a bizarre edge to his presentation,

suggesting the possible presence of delusional thinking that is being kept under wraps. His chart includes a September, 2000 admission to CNYPC and multiple diagnoses, including Delusional Disorder, PTSD with Depressive Disorder, Paranoid Personality Disorder, and Adjustment Disorder. In 12/00 he was transferred from Great Meadow to Wende because of security concerns, and evidently he has problems getting along with other prisoners, and is victimized. He seems under-diagnosed, being admitted to CNYPC for paranoid delusions while still being diagnosed Adjustment Disorder or Mood Disorder. He is prescribed Risperdal, and his chart corroborates his history. On 4/3/03 he was MH Level 1.

Example of:

SMI, probable psychosis, in ICP

Under-diagnosis

Double celled in GP in spite of SMI

Rough time in observation

X.F.

(Interviewed while housed in Keeplock).

X.F. has been in prison since he was 16. He is currently on Keeplock in General Population at Sullivan. He was transferred to Sullivan in February. He has been at CNYPC nine times, mostly because he becomes suicidal when he is severely depressed. He says they keep him only a short time because he arrives from SHU – if he were arriving from GP, he believes they would keep him at CNYPC for a longer period. He also cannot control his temper when he is depressed, and gets tickets for assault. He is afraid to tell staff how he feels because they will throw him in a strip cell, where “you are naked and cold and nobody talks to you.” He says he was in observation at Clinton for 67 days in 2001. There is no other treatment besides a strip cell, so it is overused. He has been in SHU, where he gets very depressed and has even more trouble controlling his anger. The officers in SHU treat him badly, and he is always afraid he will get additional tickets. He has received seven tickets for self-destructive behaviors, and several resulted in SHU terms. In SHU, contacts with mental health are not confidential because they occur at cell-front – and therefore he will not talk to the mental health staff in SHU, even though he becomes very depressed and struggles because he cannot control the anger that mounts when he is in SHU.

Prisoner **X.F.**'s clinical chart is consistent with the history he presented. He was at CNYPC from 9/25/02 to 10/22 and again from 10/31/02 through 2/12/03, when he was transferred to Sullivan. He is noted to have a diagnosis of Adjustment Disorder with Mixed Disturbance of Conduct, despite the fact that notes reflect multiple suicide attempts, hearing voices, a diagnosis in 12/98 upon admission to CNYPC for the third time of Schizoaffective Disorder, and during a prior admission to CNYPC, he was diagnosed Bipolar Disorder, Manic type. In a 10/31/02 Core History at CNYPC, “The patient was transferred to this facility because he hears voices. He stated he wanted to kill himself. He did display psychomotor retardation. He was very depressed. He was sleeping and eating poorly.” Again, during his seventh admission to CNYPC, he

"presented in a dysphoric state, stating that he wanted to be reunited w/his deceased grandmother...." In mid-2000, upon discharge from another CNYPC hospitalization, he started refusing medications, and for this reason was rejected from the ICP program that had been recommended. He has also been diagnosed Mallory Weiss Syndrome, and in 7/21/00, it is noted that this condition causes him no current problems. In spite of a Dx of Adjustment Disorder, he was prescribed Zyprexa 10 mg. b.i.d. dn Paxil 20 mg. b.i.d. from Feb. through May, 2003. And on a CNYPC face sheet of 2/12/03, the "Primary" diagnosis is Bipolar Disorder, Manic Type. There are many self-harm/suicide incidents, many stays in observation at multiple institutions, and quite a lot of time in SHU and/or Keeplock. A 3/10/03 progress note (after he was returned to SHU at Sullivan following a stint in observation from 2/13 through 2/18/03 to serve a three-month SHU term): "... X.F. related that the medication is, in fact, fine. He hasn't felt depressed, or heard voices, just feels anxious about being in SHU another couple of months. He was reassured regarding this. He will be followed up, as usual - Dr. Kathpalia, M.D." He has intermittently been cooperative and then refused to see or talk to MH staff or to take medications. He has attempted to harm himself while in observation on several occasions, and he has presented very big management problems, especially when he is in SHU or on Keep-lock. In summary, this prisoner is severely depressed and likely suffering from a severe Axis I mood disorder, most likely Bipolar Disorder with intermittent psychosis, acts out, often with self-harming behaviors, is not very cooperative in treatment, has been admitted to CNYPC on at least seven occasions and has spent a large amount of time in observation. Meanwhile, he is often underdiagnosed as an Adjustment Disorder even while being prescribed strong doses of anti-psychotic and antidepressant medications. He is in Keeplock in GP now, but has spent a lot of time in SHU for behaviors that are possibly linked to his mental illness, e.g. self-destructive acts.

Example of:

SMI/depression, currently in ICP, was in SHU

Tickets for self-harm

Naked and cold in observation for two months @ Clinton

Long time in SHU with cycling to observation and CNYPC and back to SHU

Bedford Hills Correctional Institutional - 5/6/03

E.E.G.

(Interviewed while housed in observation).

E.E.G. has been in prison since 1992, and was in the ICP since it opened in 2000. She reports she has cut herself many times, and shows many scars. She began a long series of suicide attempts by jumping off the third floor of the old hospital after losing an appeal in 1993 or 1994. She says "they say you get therapy in ICP, but you don't." She has been to SHU one time. She describes an incident in February, 2002, when she refused to sit in the BOSS chair and they "took me down." Officers cut off all of her clothes. She is currently on Keeplock status. It is very cold in observation. She banged her head on the metal of her cell for an hour and no staff came to see what was

going on. Her therapist comes by in the morning and talks to her at cell-front, and her psychiatrist sees her only at cell-front as well. There is no recreation for women in observation. She is never seen in an office while in observation. She feels there is no treatment going on, especially in observation but even in ICP, and people "don't get to talk about their mental health problems." She was at CNYPC in 1990 for an evaluation for court, and since being in DOCS, she has been there 18 or 19 times. She currently takes Prozac, 60 mg. per day, and Seroquel 600 mg. per day. She does not think she is psychotic. When she gets a ticket, she believes OMH is consulted by the hearing officer. Her clinical chart fills over half of a carton. There are many admissions to RCTP and CNYPC, she is recurrently suicidal and assaultive and is placed on behavior management, SPL 1, e.g. on 11/30/02 at CNYPC. Diagnoses include Dysthymia, Impulse Control Disorder, ASPD. She is frequently self-injurious, cutting, banging head, setting fire to cell, hanging up. She is frequently in restraints. Her 19th admission to CNYPC was 7/02 - 12/02. She suffers from hyperthyroidism. She has been prescribed Depacote, Haldol, Klonopin, Vistaril. In 7/03, two months after our interview, she made another suicide attempt by hanging, was not damaged physically, and was re-admitted to CNYPC. In summary, this prisoner presents a very complex and difficult clinical picture. She is diagnosed Borderline Character Disorder, there is self-injurious and acting out behavior, she is repeatedly hospitalized, she is not cooperative with medications. She suffers from hyperthyroidism. One wonders about the presence of psychosis or mood disorder with psychotic features. But ICP, where she has been for years, is probably the best treatment environment for her.

Example of:

SMI in ICP w cycling to observation & CNYPC

Harsh treatment in observation

W.C.

(Interviewed while housed in observation).

W.C. had been transferred from SHU to observation and had been in SHU (or on Keeplock status) since July. Prior to that, she had been in ICP because, she reports, she is "Bipolar and explosive." She has been admitted to CNYPC, she has had episodes of fighting, she has tried to stab herself and she has trashed her cell. It was after another prisoner, X died, that she tried to strangle herself and was admitted to CNYPC. She is prescribed Seroquel and Trazadone, and has been prescribed Depacote in the past. She claims she was "beaten" by COs on the way to observation. She has a two year old daughter, and says she came to prison while in a post-partum depression, as a parole violator. She has been "recycling" between SHU and observation. She was abused as a child and suffers from flashbacks, but now her flashbacks include scenes of being beaten by officers. A month prior to our interview she tried burning herself while in an observation cell, and was sent back to SHU. She has a very hard time in SHU, it is very loud, and she has traumatic memories of her friend dying there. She gets depressed and cries a lot while in SHU. She would like to go to the ICP. She suffers from asthma as well as panic attacks. In SHU, she is unable to concentrate, and, for example, finds herself reading the same paragraph over and over again without any comprehension.

Alternatively, she paces incessantly in her SHU cell. In observation, she reports she is never removed from her cell, not to exercise and not to speak to clinicians. They come around but only talk to her at cell-front for a few minutes. She filed a grievance about the assault by a CO. She has a psychiatric history dating to pre-incarceration times, she was civilly committed and prescribed Mellaril and Haldol. Her clinical chart is consistent with the history she presents. She had several pre-incarceration admissions to "Rockland Child" from 1995-1998, or since age 13. Her diagnoses include substance abuse, Adjustment Disorder, Borderline Character Disorder, Conduct Disorder, Intermittent Explosive Disorder, Posttraumatic Stress Disorder, Dysthymia, and Major Depressive Disorder. When she re-entered DOC in 2001, she was seen by mental health, admitted to CNYPC, and history points to explosive outbursts and chronic self-harming behaviors. In Sept., 2002, she was at CNYPC on an SPL I. She cycled several times between SHU and observation for suicidal thoughts/behaviors from 12/02 through the summer of 2003. She was described repeatedly as labile and agitated. She was placed on a treatment plan of gradual incremental rewards for good behavior as of May, 2003. A 6/23/03 note mentions "Pt. is adamant about not being admitted (to observation). She was transferred to ICP on 7/30/03, and, except for repeated admissions to observation and RCTP, she remained there at least through note of 10/23/03.. An 8/7/03 progress note reflects her concern about sharing past traumas in a therapeutic setting, and there was mention of domestic violence. She was prescribed Seroquel and Trazadone. By 9/11/03 her dosage of Seroquel was raised to 800 mg./day and she was prescribed Welbutrin 150 mg. In the past, she had been prescribed Depacote. She was admitted to RCTP on 11/11/03 with stab marks on her arm and complaints about COs, and on 11/13/03 she was discharged back to ICP from the dorm. A 3/3/04 progress note reflects testimony given for disciplinary hearing. In summary, this woman is very disruptive and chronically self-harming. She is given various diagnoses, is prescribed anti-psychotic and antidepressant medications (previously mood-stabilizing), and cycles between SHU, observation and CNYPC. She has also been in ICP without noticeable improvement in disruptive pattern.

Example of:

SMI (likely Bipolar) in SHU

Cycle to observation

Deteriorate in SHU

Complaint of poor therapy in ICP

B. B. C.

(Interviewed while housed in SHU).

B. B. C. has been in prison since 1998, and will be leaving in September. She says she has an anger problem, she gets depressed but she is not suicidal, and she takes Seroquel to help her sleep. She is sent to observation when her anger gets out of control. She has witnessed other women being beaten in observation. She feels there is something wrong with the security staff in observation, and they like to beat women. She is unable to read in SHU because of the incessant noise. She has never been to CNYPC, but she has been in a substance abuse treatment program. Her clinical chart corroborates her history. She had history of psychiatric treatment for a mental disorder that involved

hallucinations prior to incarceration. From Jan. through June, 2003, there are weekly progress notes about contact in SHU. Her dx is deferred, or she is diagnosed conduct disorder or impulse control disorder. She is prescribed Seroquel for "insomnia," 200 mg. twice per day as of 1/29/03 – with no good rationale nor report of efficacy (what logic is there in taking a sleeping pill twice a day?) Notes are poor, with no adequate medication rationale. She is occasionally sent to observation complaining of self-harm ideation. On 8/12/03, she was discharged from the OMH caseload. In summary, this young woman is not adequately diagnosed, but she is given relatively high dosages of the anti-psychotic Seroquel, and cycles between SHU and observation.

Example of:

Depression in SHU

Complaints of harsh SHU conditions

Mental functioning diminished in SHU

Cycles to observation and then back to SHU

Discharge from the OMH caseload

F.F.Y.

(Interviewed while housed in SHU).

F.F.Y. has been in prison for four years and expects to be released in 2007. She is currently prescribed Seroquel, 1,000 mg. per day, and Vistaril. She has been at CNYPC at least twice. She has been involved in altercations. She experiences hallucinations and delusions when she is enraged and involved in altercations. But she receives tickets, mentions to the hearing officer that she is a mental patient, and she claims no consideration is given to her mental health status. She has lost 60 pounds from not eating in SHU at Albion. In SHU at Albion the psychologist is always in a rush and talks to her briefly at cell-front. When she arrived at Bedford Hills she was placed in observation for nine days. She relates that she has been paranoid and hearing voices since she was 15, at which time she began taking psychiatric medications. In SHU she has problems with her memory and concentration. She gets disoriented and agitated and the voices bother her – she thinks there is someone outside of her cell "messing with me." She believes people are listening to her and watching her, and that there is a camera in her cell. She had a period of two years in GP at Albion without a ticket. She has attempted suicide by cutting her arms. She had previously been sent to CNYPC because of an overdose. Now her therapist sees her in an office. She stays in her cell for weeks or months because she is too paranoid to leave it. She is frightened by what she considers abuse by officers of women in observation. It hasn't happened to her, but she is terrified that it will. She watches cell extractions in observation and is horrified. She thinks the SHU and observation at Albion are much worse than at Bedford. Her clinical chart describes violent tics, paranoia and visual hallucinations involving seeing people in the walls. She was admitted to CNYPC for the first time on 7/25/02, to be discharged on 10/17/02. She had been in St. John's psychiatric hospital prior to incarceration. Her clinical chart is consistent with the history she provides. In Feb., 2003, she was in CNYPC inpatient and on SPLI observation, periodically in restraints, acting belligerent. She is prescribed anti-psychotic medications as she reports, and in the past she has taken

Haldol, Seroquel, Zyprexa and others. She is noted to be recurrently very suicidal, to experience hallucinations, but when admitted to CNYPC she is agitated, oppositional and belligerent. Diagnosis is Paranoid Schizophrenia or Psychosis NOS. A 1/6/03 Update of her inpatient core history notes her being convicted in court of assault on another prisoner at Albion and being given additional years on her current sentence, to be eligible for release in 2007 instead of 2004. Third admission to CNYPC is 8/1/03 through 9/16/03. She is both psychotic and disruptive, noted to be assaultive, she also threatens to "hang up," and is considered a suicide risk. On 11/24/03 she is at CNYPC, fourth admission, on SPL 1, and disruptive. On 12/4/03, news arrived at CNYPC that her brother had died. Soon after, she seems to have calmed down, was grieving, and could be advanced to SPL 2. She was discharged to Bedford Hills, first to OMH Unit and then back to SHU. She is consistently diagnosed Schizophrenia and remains on anti-psychotic medications. She needs to be removed from SHU and transferred to a long-term mental health setting such as ICP.

Example of:

Psychosis (Par. Schiz.) in SHU

Does poorly in SHU

Cell-front interviews

Outside criminal case

Cycles to observation/CNYPC & back to SHU

E.E.I.

(Interviewed while housed in SHU).

E.E.I. has been in prison for 11 years. She is seen in SHU, where she has spent over four years. Before that she was in general population. She states she was half way through a doctoral program prior to entering prison. On mental status examination she exhibits pressured speech, agitation, some anger and difficulty putting many sentences together into a coherent line of thought. She is taking no medications and is not receiving mental health help; she says because there is no confidentiality. She says the isolation in SHU is devastating, there are no programs, and staff tell her that if she goes on a visit she will be strip-searched and the time will be counted against recreation. She says she is on involuntary protective custody because other prisoners threaten her, but she does not want PC. She complains that DOCS does not make it safe for her in general population. She says she sleeps all the time in SHU, is depressed, finds herself cursing a lot, and suffers panic episodes. Her clinical chart discusses agoraphobia and anxiety, with an admission to RCTP on 2/6/02. She has another admission to RCTP in Jan., 2004. OMH notes go back to 1993, reflect anxiety, depression, agoraphobia, etc. – fears re safety in GP – but no dx, no meds, and she is sent from RCTP to SHU when doing SHU time, with talk of PC but no protection initiated.

Example of:

Depression in SHU

Cycles to observation and back to SHU

Harsh treatment in SHU

E.R.

(Interviewed while housed in SHU).

E.R. has been in prison since July, 2002, was seen in SHU, where she has been since August, 2002. She has received between 30 and 60 tickets. She says she is very frightened, and is on her way to observation where she has been before. She has tried to hurt herself in the past, but says she is merely stripped naked and kept in an observation cell where she receives no mental health treatment. She claims she cannot control her tendency to talk loudly, but raising her voice in SHU results in more tickets. She describes a vicious cycle where she loses control of her voice in SHU, talks loudly, and then gets more tickets which mean more time in SHU. She is not taking psychiatric medications presently, and had a side effect of hair loss. She would like to be in group psychotherapy. She reports she was beaten in observation and believes this happened because she was unwilling to "get naked in front of men." She has been to observation four or five times. She has been in observation for 16 days, and has never been at Marcy, nor in ICP. She received Social Security disability (SSI) when she was on the street because of mental illness and mental retardation. She was in Special Education all of her life. She has two sons and a daughter who come to visit her.

Example of:

SMI in SHU

Dysfunctional in SHU

Shouts, leads to more tickets

Cycles to observation and back to SHU

Rough treatment in observation

R.P.

(Interviewed while housed in SHU).

R.P. has been in prison since 1994. She had been diagnosed Manic-Depressive prior to entering prison, and she is currently prescribed Seroquel 800 mg. per day. She states it is the wrong medicine, "but they won't change it." She is also prescribed Tegretol and Paxil. She has been to observation four times, each time because of self-destructive behavior. She says nobody comes to see her after she expresses suicidal intentions, and then she tries to cut herself or hang herself. She never did anything like that on the streets. She was in ICP for seven or eight months. She describes "the worst abuse" as being beaten while being taken to observation. She also claims she is beaten while in observation. She sees a therapist each week and a psychiatrist every two or three months, but both see her for only a few minutes. She tells me she gets tickets for trying to harm herself. She is short and muscular and masculine-appearing. Her 15 inch thick clinical chart includes record of three or four admissions to CNYPC w diagnosis Schizophrenia. She has a pre-incarceration record of multiple

psychiatric hospitalizations with diagnoses including Bipolar. Her meds at Bedford Hills included Seroquel, Klonopin, Paxil and Haldol. She also takes seizure meds and has had a seizure work-up, including brain imaging. Her third admission to CNYPC was on 3/17/00 for Depression with command hallucinations and suicide intention. By 7/10/01 she was admitted to CNYPC for the fifth time, diagnosis Major Depressive Disorder, Borderline Personality Disorder and Seizure Disorder. She took a large combo of meds, including the above plus Thorazine, She underwent some Dialectical Behavior Therapy (DBT). Suicide continues to be the issue, plus disruptive behavior triggering 5-point restraints, prn anti-psychotic injections, etc. Chart through 8/01, continues to be hostile, danger to self, and require meds cocktail plus intermittent restraints. This woman obviously suffers from SMI, there are notes in chart about her exaggerating some symptoms, but she is consistently diagnosed Maj. Depressive Disorder, often with Psychotic Features, and she is given a cocktail of anti-psychotic, mood-stabilizing and antidepressant medications. She should not be in SHU, but needs long-term mental health treatment such as ICP.

Example of:

SMI (Bipolar or Schizophrenia) in SHU

Cycles to observation and CNYPC and back to SHU

Functions poorly in SHU

G.Z.

(Interviewed while housed in ICP).

G.Z. has been in prison since 1996. She was admitted to CNYPC once, six months ago. She says "there's abuse – the COs push you to your limit where you have to hurt yourself." She was admitted to ICP after returning from Marcy. She complains that observation is very cold. She reports that she received a ticket for cutting her neck. She is very depressed. She suffers from memory problems. On mental status examination, it is clear this woman is depressed but also has impaired orientation and memory and below average intelligence. She is prone to suicidality if upset. She does not have any family. She has not received a GED. She is prescribed Prozac, 60 mg. per day, and Trazadone, 100 mg. at bedtime. She has been sent to SHU once because she refused to take her medications. The mental health staff arranged to get her out of SHU. She likes her therapist, who sees her for a half hour every Thursday. Her clinical chart is consistent with the history she reports. Her Diagnosis is Depressive Disorder NOS. She is prescribed Prozac 60 mg. per day. She was at CNYPC in October, 2002. She was also in observation at CNYPC in 9/03 and 10/03 for suicidal crisis.

Example of:

SMI (Depression) in ICP

Removed from SHU per OMH staff

H.K.

(Interviewed while housed in ICP).

H.K. in DOCS for 90 days on a parole violation. She served a year in 2001-2002. She is in ICP after spending 30 days in the mental health satellite. She says she suffers from OCD (obsessive compulsive disorder) and PTSD (posttraumatic stress disorder). She had been in SHU at Albion and had a very rough time there, feeling she was hassled by the COs. She is prescribed Sinequan, Luvox, Paxil and Klonopin. She has suffered from mental illness since childhood. She was in psychiatric hospitals at least three times prior to entering DOCS. The diagnosis that sent her to the hospital was Depression. She has made several suicide attempts. She has five sons and a daughter, but does not want her children to visit her in prison. She complains that the COs at Albion are mean and brutally beat women prisoners. Her clinical chart is consistent with the history she presents. She is diagnosed PTSD with substance abuse and possible Borderline Personality Disorder on 2/27/03. Medications include Seroquel 800 mg., Paxil 40 mg. and Luvox 200 mg (quite strong dosages of two antidepressants plus an atypical anti-psychotic agent – an unusual medication regimen for PTSD alone.) She is in ICP, and there are notes about past sexual abuse, suicide attempts, paranoia and disorganized thinking. She had earlier been diagnosed OCD. Notes do reflect her having emotional difficulties, and earlier abuse with PTSD is reflected often and related to current emotional crises. It does seem, from chart review, that this prisoner would react strongly to being roughly handled by male officers.

Example of:

History of trauma

PTSD & OCD in ICP

Medications unusual for diagnoses

S.Q.

(Interviewed while housed in ICP).

S.Q. came into DOCS in 1995. She has been in ICP for five years. She has been in observation, Keeplock, and now she is in ICP step-up. She overdosed on Klonopin on 9/13/02. She is now prescribed Seroquel and Zoloft. She suffers panic attacks and insomnia. She likes the therapist she sees monthly for 15 or 20 minutes, but is upset with her psychiatrist because the doctor won't talk to her about the son who was killed a year ago. She has been admitted to CNYPC once. She had many psychiatric hospitalizations in the community for Dissociative Disorder and Depression with suicidality. She gets restless legs from the Seroquel. She says that since she has been in prison she has wanted to die. She has never been in SHU. She has done a lot of time in Keeplock. When she becomes depressed she starts thinking about killing herself. She has lost a lot of weight. She is currently depressed, is losing weight and is unable to sleep, and in this state she stays to herself and does not take showers. It was my

impression that she might be taking too much Seroquel, and this could be contributing to her depression. In her clinical chart there are diagnoses of Borderline Personality Disorder and Histrionic Personality Disorder with polysubstance abuse. She had a pre-incarceration mental health record of treatment for Dissociative Disorder and Major Depressive Disorder. She made suicide attempts and was sent to observation. She was admitted to CNYPC on 1/30/02, suicidal, precipitating event being the death of her son. She is prescribed a combo of mood stabilizer (Depacote), antidepressant (Paxil) and anti-psychotic (Seroquel &/or Zyprexa).

Example of:

Depression & Dissociative Disorder in ICP

Sing Sing – 5/7 – 5/8/03

C.C.K.

(Interviewed while housed observation).

C.C.K. has been in prison for 11 years. He was released last May and remained in the community for five months until his parole was violated in 10/03. He has been in observation for two days because he wanted to kill himself. He has a long history of Depression in prison. He was in CNYPC in 1999. He has served quite a bit of time in SHU, but at one point the OMH staff at Sullivan gave him a time-cut, and he was in general population at Sing Sing prior to transfer to observation. He tells me that in observation one does not see the staff very often nor for very long, and then only at cell-front. He is not taking medications, and does not see OMH staff outside of observation. He says that while he is in observation he refuses to come out of his cell to talk to mental health staff because he is frightened. He had been in ICP. He complains that COs treat all "mental health guys" as if they are a threat. He has done a lot of time in SHU, and definitely his depression gets much worse in SHU. He also experiences panic attacks in SHU, and becomes frightened that he will never get out. Just prior to this admission to observation he had been giving away all of his possessions and preparing to hang himself. He feels better now that he is safe in observation, but he feels that he needs one-on-one psychotherapy so he can talk to someone about his feelings – and he definitely does not get that in observation. He feels he should be in a Medium Security facility, and if he were in Medium he would not be so depressed. On his mental health chart, he is noted to be a Mental Health Level 6 in January, 2003, then a 3 in April, 2003, and a 1 now. This in spite of many admissions to CNYPC noted. In other words, this prisoner suffers from chronic serious depression, and is sometimes treated at CNYPC or observation, but then is essentially discontinued from treatment until the next time his depression leads to a suicide crisis, usually in SHU.

Example of:

SMI (Depression) in observation

Has spent much time in SHU, with worsening Depression

Multiple admissions to observation and CNYPC

Dropped from treatment between acute exacerbations

C.O.

(Interviewed while housed in SHU).

C.O. is clearly suffering from a chronic psychotic condition. He exhibits a tremor (possibly related to psychiatric medications), he is anxious and very anxious to please, and he exhibits pressured speech. He has been admitted to psychiatric hospitals in the community six times, and has had ten prison terms. This is his third SHU term, and it began in February, 2003. He received a ticket for breaking the no-smoking rule and then getting into a fight with a CO about it. He was previously prescribed Haldol, 10 mg. per day (in spite of likely tardive dyskinesia), Cogentin, and Zyprexa 1 1/2 mg. per day; but on this bit he is not taking psychiatric medications even though medications were offered to him. He hears voices telling him "I'm the Creator, I'm God." He does not try to harm himself. The only contact he has with mental health staff is that the psychiatrist comes to see him briefly at cell-front "once in a while." A nurse brings his medications (but he said he does not take psych meds – he reports a head injury in the Marines in the early 80's, and that he takes medications for that all the time). He has been admitted to CNYPC several times while in DOCS. He had a questionable competency examination – details unclear. He was in ICP at Attica and liked that program. On mental status exam he exhibits very strong First Rank Symptoms. This man suffers from chronic Paranoid Schizophrenia and is housed in SHU following assault on an officer. His medication status is unclear from his history. He does not claim command hallucinations were involved in the assault. His clinical chart is consistent with this history. His diagnosis is Paranoid Schizophrenia, he is not very treatment-compliant. He has been medicated with Haldol, Zyprexa, etc. He is left for long periods in SHU with little if any treatment, always considered SMI, but minimally assessed/treated. A Treatment Plan of 10/21/03 reflects he is in ICP and has been for a month, but is aggressive and on Keeplock. Notes reflect that he remains in ICP, is intermittently not motivated or fails appointments, but takes his medications (combo of Zyprexa, Haldol and Cogentin), through April, 2004, when chart ends.

Example of:

Prisoner with SMI (Schizophrenia) who spends much time in SHU

Multiple admissions to observation and CNYPC

Not very compliant with treatment

Eventually transferred to ICP, where he does better

J.A.

(Interviewed while housed in SHU).

J.A. has been in prison since December, 2001, after serving extensive jail time. He is seen in the SHU at Sing Sing on 5/7/03, his first term in SHU, where he has

been since Dec. 26, 2002. His ticket was for being agitated and making noise. He says he was hearing voices at the time, the voices "were telling me lies, telling me to protect myself." He did not raise his mental illness as a defense at the time of the hearing, and he reports that as far as he knows OMH did not report to the hearing officer that he suffers from mental illness (there is no note in his clinical chart reflecting a report to the hearing officer). He says he is Bipolar and Schizophrenic, and he is not proud of it. At the time of the incident that led to his SHU term he was taking only an antidepressant (actually Depacote, a mood stabilizer), which did not help with the voices. He believes he is someone besides himself. Prior to incarceration he was hospitalized on a psychiatric ward at Metropolitan Hospital. He finds himself crying when in general population. Because he complained he was worried about that symptom, he was transferred from Fishkill to Sing Sing so that he could receive mental health treatment. In the process, he was reclassified from Medium to Maximum merely to receive mental health services. But then, soon after entering the max facility, he received a ticket that led to a SHU term. He is currently prescribed Depacote, 1,000 mg. per day, Zyprexa, 20 mg. per day, and Atarax for sleep. He feels the medications help, and he is calmer when taking them. He only sees mental health staff when they tour the SHU, and only at cell-front for a few minutes. Once every four months he is taken to an office to talk to mental health staff. When mental health staff query him at cell-front, he does not tell them anything because he does not want to be overheard by others. He gets depressed and agitated in SHU. He tries to read and pass his one year term without getting into more trouble. He was offered STP and refused. He has gained ten to 20 pounds since December. He did not appeal his ticket within the 30 day deadline because he is shy and afraid of stigma if he admits he suffers from mental illness. His chart is consistent with this history. He is diagnosed Bipolar Disorder. It is noted that he had a pre-incarceration history of psych hospital admissions. He has been in observation for self-harm. Notes from rounds in SHU are consistent with his report he won't talk about his problems during cell-front interviews. He was admitted to CNYPC in 7/03. He is prescribed anti-psychotic (Haldol, Seroquel, Zyprexa at different times) and mood-stabilizing (Depakote) medications. He was admitted to the re-entry program in 9/03 and was still there in 11/03, when the chart I reviewed ends. In summary, this mostly well-behaved man with chronic serious mental illness trashed his cell at the behest of command hallucinations and served a one-year SHU term for that.

Example of:

**Prisoner with SMI (Bipolar with Psychotic Features) who spends much time in SHU
SHU makes mental illness worse**

Command hallucinations involved in behaviors that led to ticket

No known participation by OMH in hearing

Cell-front interviews in SHU preclude real understanding of his emotional pain

W. I.

(Interviewed while housed in A Block).

W. I. has been in prison since 1990. He was taking Zyprexa and Haldol, but the medications were discontinued two and a half months ago. He hears voices,

calling his name and accusing him of robbery. He has been at CNYPC ten times. He sees OMH staff regularly. He has not been in SHU at Sing Sing, but was in SHU at Auburn in 1999 and then at SouthPort in March, 2002. He had a four month ticket at SouthPort for telling a CO to "shut up" at the behest of voices. He was prescribed Lithium and Mellaril at the time, and he believes OMH was not involved in his hearing. He has migraines that date to a car accident when he was three years old. He also has scars on his forehead from the accident. He was in observation a few months ago because he was hearing "tapes" (voices). He has been at ICP at Sing Sing. On mental status exam, this man exhibits very loose associations, tangential thinking, pressured speech, bizarreness and flat affect. He says he is afraid for his life and that "they poison the water and food." He has severe First Rank Symptoms. When he is in SHU the voices become louder and he experiences more serious First Rank Symptoms. He used illicit drugs as a teenager. This man suffers from chronic psychosis and is currently functioning adequately on medications in population. He is prone to tickets for behaviors that are fostered by command hallucinations, and the time he has spent in SHU has made his psychosis much worse. His clinical chart corroborates the history he presented. His diagnosis is Schizoaffective/Bipolar Disorder. He has been admitted to CNYPC on multiple occasions, has been in and out of SHU, is prescribed anti-psychotic (e.g. Zyprexa) and mood stabilizing (Depacote) medications, and is generally a disruptive and very disturbed individual who has remained in treatment with OMH throughout his period of incarceration.

Example of:

Prisoner with SMI (Schizoaffective Disorder) in GP currently

Has spent time in SHU with worsening condition

OMH is not involved in disciplinary process

Multiple admissions to CNYPC

Currently doing well in treatment & GP

Prisoner . E . E . B (Interviewed while housed in Keep-lock).

E . E . B says he has been in prison for 23 years on a second term, 15-to-life. He is currently in Keep-lock on a 90 day term on A-Block at Sing Sing, and he was in SHU a few times in 2000. He does not feel he has a mental illness. He is not taking medications. He complains of being denied proper medical care for Hepatitis B & C, and he believes he is unable to get to see the doctor. He has not been to CNYPC, and is not on medications though the doctor wants him to take antidepressants. He believes they are using a gamma ray device on him, and the mental health staff know about the device. They place something in his rectum which gives him a vibrator effect. They selected him to oppress in this way because of "The Blue wall of silence." Staff are able to hear all of his private thoughts. He has been in SHU, and it was terrible.

The clinical chart reflects he was at CNYPC, admitted for belligerence and agitation and mood fluctuation, discharged 8/27/01 because he refused to give a history, refused treatment, and wanted to be discharged. He has been to RCTP, and he is a MH

Level 1. He is diagnosed Delusional Disorder and ASPD, and refuses meds. No psych history prior to 2001 per sister's report, in chart, but when delusions identified in 2001 by MH, it seems they were already established and fixed. A 1991 mental health evaluation when he was admitted to SHU states he had no mental health problems.

This prisoner obviously suffers from Paranoid Delusional Disorder and is in Maximum GP, being seen by MH but not taking any psychiatric medications. If, as on 2/13/03, he is reported in a Treatment Plan Review to be paranoid, delusional and to have poor reality-testing; why does mental health staff not intervene to prevent his being placed on Keep-lock?

Example of:

Prisoner with SMI (Paranoid Delusional Disorder) on Keeplock in GP

Has been in SHU

Non-compliant with mental health treatment

Prisoner **G.G.I.** **(Interviewed while housed in A Block).**

G.G.I. has been in prison since 1991 on his third term. He is housed in A Block at Sing Sing and is seeing a mental health clinician for counseling. He has been admitted to CNYPC four times and has been in observation very many times, for as long as two weeks at a time. He denies being suicidal. He believes he suffered a first breakdown in 1995 while in "the Box" (SHU) at Southport. He has been returned to "the Box" on several occasions after being discharged from CNYPC. The longest stint he served in SHU was one year. The first time he went to SHU he was "out of control" at Attica and was not able to get to see the mental health staff. Someone from mental health came to his cell front to "chat," but he did not consider this to be treatment. He suffers from mood swings, thought he was Jesus Christ on one occasion when he was transferred to CNYPC, but does not remember whether he hears voices when he is acutely disturbed. He has been offered ICP, but refused because he had a job he wanted to keep. He does not take psychiatric medications at present, by his choice. He is single and his mother visits approximately every two weeks. On mental status exam, this man has a severe stare, is very concrete, there is some bizarreness and one senses he is internally preoccupied with hallucinated voices but does not admit to same, and while he does not aver hallucinations nor delusions, seems to be suffering from a chronic serious mental illness.

G.G.I. clinical chart essentially confirms the history he reported, except that more severe mental illness, with hallucinations, delusions and assaultiveness in response to command hallucinations are noted during admissions to CNYPC. He has been admitted to CNYPC on four occasions. He was at MH Level 6 through June, 1996, and has mostly been at Level 1 since. He is diagnosed Bipolar Disorder with Manic episodes. He has been prescribed Haldol and Depacote. The chart does note that he attempted to hang himself in 1996 because of command hallucinations. He tends not to cooperate with treatment, and it is noted that he can become combative or assaultive, sometimes

with no warning. He seems to have had an acute exacerbation of mental illness in mid-June, 2002, when he was preoccupied with sexual ruminations and inappropriately touched a female officer. He was sent to observation and then put on Keep-lock. His medication dosages were increased, but he intermittently refused to take them. He was considered for transfer to CNYPC but not actually transferred. He was kept in observation for well over two weeks with daily notes about his intermittent psychotic behavior. He seems to have suffered an acute psychotic/manic episode that was managed by keeping him in observation and increasing Haldol and Depacote to 15 mg. and 1,000 mg per day, respectively. He was released from observation to serve time in Keep-lock for behaviors that seem very related to his psychotic/manic condition. Notes for the latter part of 2002 and 2003 reflect monthly meetings with a clinician.

Example of:

Prisoner with SMI (Bipolar with Psychosis) in GP with no medications

History of SHU confinement and multiple admissions CNYPC

Spent weeks in observation during acute psychotic episode

Refused ICP because he wanted to keep his job

D. P.

(Interviewed while housed in ICP).

D. P. has been in ICP for one year. He has been in prison since 1988. He was in SHU once, at Wende, for pointing a finger at a hearing officer. He often feels depressed and wants to kill himself, though not presently. He has been in observation a couple of times. He is prescribed Depacote, Seroquel and Cogentin. He stopped his medications one week ago because of side effects. He hears voices related to Jesus and biblical ideas, and he believes God talks directly to him. He was sent to Bellevue psychiatry from Rikers Island once because he would not talk. He likes ICP because he feels safe. He gets very upset when placed in segregation, both in SHU and in observation. In observation it's worse because there is no recreation. He has been admitted to CNYPC five times, and once was given forced medications. He felt very suicidal when in the Box, and heard louder voices. The very thick (a carton) clinical chart is consistent with his history. He is diagnosed Schizoaffective Disorder and prescribed anti-psychotic and mood stabilizing medications. He decompensates when he non-complies with medications. In summary, this man suffers from chronic serious mental illness and is doing OK in ICP and on medications.

Example of:

SMI (psychosis) in ICP, doing OK

History of SHU term and multiple admissions CNYPC

F. M.

(Interviewed while housed in General Population).

F. M. has been in prison for five years and had three prior bits. He is in general population. He has been in observation and in SHU once, never in ICP. In SHU, he claims "they harrass you, they treat you like a murderer." He says he became very

paranoid in the Box, whereas in population he had merely been frightened. He is prescribed Seroquel, Buspar, Benadryl and possibly Neurontin. He says his medications make him sleep, so he takes them at night. When he has a breakdown, he cuts himself. He describes a pressure building up in him that makes him cut. He was transferred to Marcy in 1999, and then released, without any preparation nor arrangements for mental health care. He did not receive mental health care in the community, and he became paranoid. He had a history of mental problems and mental health treatment prior to incarceration. He describes hallucinations and delusions beginning in the mid-90's, worse in prison and even worse in SHU. He describes out of body experiences. He relates delusional material about a "black hole" he went through. At one point he was screaming in his cell in SHU, officers took him to observation where he spent two weeks, then he was sent to CNYPC and placed in 5-point restraints. He also cut himself in SHU. He was in ICP in May through August, 2002. He liked it, and does not know why he was discharged. He also had drug treatment while at Coxsackie facility. When "the power gets too strong, I feel like cutting myself." He would like to go to ICP, because he is afraid he is around too many evil people. On mental status examination, this man exhibits inappropriate affect, a very stark glare, bizarreness and loose associations, and pervasive delusional thinking. He also describes depression and frequent self-harm impulses. This man's thick (two volumes) clinical chart reveals he was in ICP and doing well in 2002. He has been in and out of observation and transferred between SHU and observation, for example on 8/6/02. He is diagnosed Paranoid Schizophrenia. He has been prescribed Haldol and Zyprexa and so forth. He was returned to GP from ICP, and expressed concerns that were discussed by his OMH therapist. In other words, his chart corroborates the story he presented, is known by OMH to suffer from Schizophrenia, has been in treatment including medications and ICP, and has been in SHU and cycled between SHU and observation.

Example of:

**SMI (Paranoid Schizophrenia) in GP, doing OK on meds with outpatient treatment
Spent time in SHU with worsening mental illness (paranoia) and multiple
admissions to observation and CNYPC
Has done well in ICP**

**Prisoner
Custody).**

P.P.O.

(Interviewed while housed in Protective

P.P.O. was in SHU for seven months and complains of being in cuffs all the time and being beaten by C.O.s. He was sent to P.C. because he'd been beaten in GP. He complains he is depressed, and reports he is prescribed antidepressant medications. In P.C. he remains in his cell all day, idle, and this makes him very nervous. He gets out of his cell from 5 P.M. to 9 P.M. and eats with other prisoners. He does recreation in a tiny "yard" with one other prisoner. He is illiterate, and has never been to school. He sees "the psych" on rounds daily at cell-front. He avers hearing voices intermittently, not on the day of our interview. He has limited English. He has been in observation 20 times, where he remains naked, and sleeps on the floor. He is taken there whenever he "hangs

up.” It is freezing in observation, and he always feels humiliated by the experience. He confides that his tickets often occur when he is hearing voices telling him to do what he eventually is ticketed for.

The clinical chart confirms the history this prisoner presented, but documents much more serious mental illness, including psychotic episodes. He was transferred to Sing Sing from Downstate and has not been at CNYPC during this term, but was admitted to CNYPC in 1996 during another term. He carries a diagnosis of Psychosis NOS, but was discharged from CNYPC after three weeks with no Axis I diagnosis except polysubstance abuse, but with prescribed meds including Depakote 1,000 mg./day, Klonopin 2 mg./day, Prolixin 20 mg./day and Cogentin. He had received psychiatric treatment, inpatient and outpatient, in Puerto Rico prior to incarceration. He was a polysubstance abuser. He has been prescribed Neurontin and Zyprexa. Auditory hallucinations, delusions and “serious impairment in judgment” are noted, he has been suicidal in the past, he cooperates with verbal therapy but intermittently refuses medications. On 11/13/02 he was overheard by a CO talking about suicide, seen by mental health that day and two more times when he denied suicidality, until on 12/28/02, he was admitted to observation for danger of self-harm. He reported command hallucinations telling him to kill himself, but on 12/30 a clinician opined he might be manipulating. He was also requesting P.C. and not wanting to go back to GP for fear of being cut by another prisoner. He made a few superficial cuts on himself in the next few days. He is seen three times by the treatment team. On 1/7/03, still in observation, he denies he heard voices. He is discharged around 1/10/03. On 1/16/03 he is seen in ER, nervous (note unclear), referred to P.S.U. He was returned to observation where he cut himself again and was noted to bang on the plexiglass. He was given intramuscular medications. Though his cutting/self-harm continues, he was discharged from observation, then re-admitted on 1/22 for cutting that staff noted was “manipulative,” and finally he was sent to PC. On 1/31/03 he is noted to be hearing voices telling him to harm himself and he is re-admitted to an observation “strip cell.” He then goes in and out of observation, with comments about “manipulating” interspersed with prescription of and raising dosages of Zyprexa and/or Haldol for “hallucinations.” Seen by OMH frequently, but mostly at cell-front in PC when he is not in observation. His diagnosis remains psychosis with depression in various places in chart. This depressed and likely chronically psychotic prisoner is also manipulative, frequently suicidal and some of the suicide attempts are related to his seeking PC status. But even after being transferred to PC he continues to self-harm. He is prescribed meds, spends a lot of time stripped in observation, and is not sent to CNYPC during this term.

Example of:

SMI (Psychosis and Depression), in Protective Custody

Spent time in SHU

Long periods in observation

Considered manipulative, un-diagnosed

Re-diagnosed and medications continued

Seems both manipulative and suffering from SMI

L.S.

(Interviewed while housed in ICP).

L.S., who is serving a life sentence, tells me he does not take his medications, has disturbing involuntary movements, is schizoid and does not want to talk to anyone, and does not want to talk to me. His thick clinical chart reflects five CNYPC admissions, a diagnosis of Undifferentiated Schizophrenia with substance abuse. A 4/30/98 note while he was at CNYPC reflects refusal to communicate, refusal to cooperate and refusal to leave his cell. A 11/01 discharge note from CNYPC warns about involuntary movements and intolerance for neuroleptic medications. He is described as very schizoid, denying problems. He deteriorated in general population. He was prescribed crushed Zyprexa and Ativan in 9/98. He has been admitted to CNYPC at least five times, decompensated.

Example of:

Prisoner with SMI (Schizophrenia) in ICP

Non-compliant

Cannot function in GP, needs to remain in ICP

H.G.

(Interviewed while housed in ICP).

H.G. has been at Sing Sing for two years, this is his sixth or seventh bid. He has never been in SHU and never been admitted to CNYPC. He has been to observation two or three times, the last time was a year ago when he got upset at a CO. He has received a ticket for screaming, which was dismissed. He has been taking psychiatric medications since age ten, and he has been hearing voices since age 18. He is prescribed Prolixin, and has a tremor that is better when he relaxes. He feels ICP is OK, but a lot of the prisoners sleep all day. He would like more programs in ICP. On mental status this man suffers from obvious tardive dyskinesia, and displays flat affect and concreteness. His very thick clinical chart corroborates the history he presents. His diagnosis is Schizophrenia, Undiff. Type or Paranoid type. He has been on Prolixin by injection for 13 years. In summary, he is suffering from chronic Schizophrenia and is coping adequately in ICP, though he complains of the lack of programs and he suffers from tardive dyskinesia. I do not understand why he remains on a neuroleptic with tardive dyskinesia – he should be prescribed an atypical anti-psychotic, and since Risperdal is now available as long-acting intramuscular preparation, he should be tried on oral meds or his parenteral medications should be changed.

Example of:

SMI (Schizophrenia) in ICP

No SHU term

Has tardive dyskinesia, yet still on neuroleptic

M.J. (Interviewed while housed in ICP or CORP).

M.J. has been in prison for 36 years. He had been in psychiatric hospitals prior to incarceration, including Mattawan, Mid-Hudson and Creedmoor. He has a court order for treatment over objection. He does not wish to be interviewed. A review of his chart discloses that he was in CNYPC in 1992, and has been switched more than once from a Mental Health Level 1 to a Level 6. He has been in ICP since 1993 with a diagnosis of Paranoid Schizophrenia. A report of a 1974 psych evaluation reflects that he is "very psychotic, Paranoid Schizophrenia, and uncooperative." He is prescribed Haldol and Cogentin and goes to recreation, but he resists group therapy. In other words, this man suffers from chronic Schizophrenia and has been in ICP for many years.

Example of:

SMI (Schizophrenia) in ICP

Switched from MH Level 1 to 6 and back repeatedly

G.L. (Interviewed while housed in ICP).

G.L. has been in prison for 18 years. He has never been in SHU, and has been admitted to CNYPC twice in 1988 and 1991. He is prescribed Vistaril and Trazadone, and in the past was prescribed Sinequan and Prozac. He says his problem is recurring depression, and when he is depressed, he hears voices. He has not been to observation for years. He thinks ICP is "OK," and he attends groups. He finished the eighth grade in school, and has worked at a gas station. On mental status this man exhibits a bizarre stare, is flat and concrete, and appearance, affect and thought process are consistent with chronic Schizophrenia in remission on medications. His four inch clinical chart corroborates his history, his diagnosis is Chronic Undifferentiated Schizophrenia, he has been in ICP - previously he'd been denied ICP admission because of disciplinary problems.

Example of:

SMI (Schizophrenia) in ICP

No SHU term

R.H. (Interviewed while housed in ICP).

R.H. has been in prison over ten years, and in ICP for two months. Before that he was in population - he has not been in SHU at Sing Sing. He did two SHU terms at Auburn, 15 months and six months, and while in SHU he was sent to observation. He had a serious drug problem on the streets, and drug abuse resulted in his returning to prison five months after his first bit ended. He went through drug treatment at

Greenhaven Prison. He has a history of mental illness since age 18, with a diagnosis of Paranoid Schizophrenia. He says that "prison breaks you." He does not like to be in population because other prisoners victimize those with mental illness. He used to get into arguments with COs, and tells of being beaten by COs in 1995, but now he "uses my head" and stays out of trouble. He works in welding. He has not had visits for ten years – he explains he does not want the officers to get at his family. He likes the ICP at Sing Sing better than the one at Auburn, because you get out of your cell more, there are televisions on the block, and there are tables where he can play checkers. He is currently prescribed Seroquel, 200 mg. twice per day, and Cogentin. He feels the officers do not pick on him as much in ICP, and he feels he is in fairly good shape right now. On mental status, he exhibits loose associations, flat affect, reports hallucinations and seems concrete. A review of his chart discloses three or four admissions to CNYPC between 1995 and August, 2000 – October, 2001. He suffers from auditory hallucinations and becomes assaultive with officers when he does not take his medications. He was transferred from CNYPC straight to the Auburn SHU in 1996. He had been on the psych. Ward at Kings County Hospital at 18, he was subsequently admitted to a couple of more hospitals in the community, usually with psychotic symptoms linked to assaultiveness. There are incidents where he refused to take his medications, became assaultive in DOCS, and had to be admitted to CNYPC. His fifth admission to CNYPC lasted for 415 days, from August, 2000 through October, 2001. In summary, this man suffers from chronic Schizophrenia and is currently stable on Seroquel in ICP.

Example of:

SMI (Schizophrenia) in ICP

Had been in SHU, with negative effects, and multiple admissions to CNYPC

V.L. (Interviewed while housed in B Block General Population).

V.L. has spent 22 years in prison. He had been in ICP for one year three years prior. He has been at CNYPC nine times, mostly for depression and not communicating. He says he halts his medications and withdraws, and that is when he is transferred to CNYPC. He was in SHU for nine months in 1987, but did not go to CNYPC from there. In SHU, he withdraws and gets depressed, or he gets into fights. He is currently prescribed Prolixin and Prozac and sees a mental health worker every two weeks. He complains of being abused by other prisoners because he is mentally ill. He has an AA degree in business. He has been in observation 15 times, the last two years ago. He merely sleeps all day in observation. He has no complaints about the treatment he received there. His mental status reflects flat affect, concreteness and a credible history for chronic Schizophrenia with no active signs. This prisoner's very thick (an entire carton) chart reflects a diagnosis of chronic undifferentiated Schizophrenia, is prescribed Prolixin, and has been admitted to CNYPC on many occasions, usually when non-compliant with medications. Typically, he becomes withdrawn, his hygiene deteriorates, and he is found to be hallucinating and irrational. He is diagnosed Schizophrenia, has spent little time in SHU, and seems to be managing in GP.

Example of:

**SMI (Schizophrenia) in GP, doing OK with treatment
Has been in SHU, CNYPC and ICP**

A.X.

(Interviewed while housed in ICP).

A.X. has been in ICP for five years, and in prison for 17 years. He was in SHU once in 1993. He has been admitted to CNYPC six times, and is currently taking anti-psychotic medications. He had a horrible time in the Box, became very nervous and could not relax and suffered a mental breakdown under the stress. He does not like the side effects of his medications, but takes them in order to stay in control of his "bugging out." He thinks the ICP is OK, but he hates observation, where "they don't treat you like a person." His chart corroborates his history. His Dx is Par. Schiz., he periodically non-complies with medications and becomes delusional with disorganized behavior and thinking and needs to be admitted to inpatient, he is prescribed Risperdal 4 mg. per day plus Haldol Decanoate.

Example of:

**SMI (Schizophrenia), in ICP, doing OK
No SHU since 1993, but did poorly there at that time
Finds observation traumatic**

E.Q.

(Interviewed while housed in CORP).

E.Q. is in the CORP program, being in prison for a parole violation and getting ready for release very soon. He has a long history of substance abuse. He does not like the side effects of psychiatric medications, so he refuses to take them and the staff do not force him. He is not in mental health treatment. On mental status, there are loose associations, flat affect and concreteness suggestive of chronic Schizophrenia. A review of this man's chart reveals a diagnosis of Paranoid Schizophrenia, many admissions to CNYPC, Mental Health Level 1, and frequent refusal of treatment and medications.

Example of:

**SMI (Schizophrenia), in CORP program preparing for discharge
Not in mental health treatment
Actively psychotic, but doing OK**

L.C.

(Interviewed while housed in ICP).

L.C. has been in prison over three and a half years, did all of his time in Sing Sing, is currently in ICP, and is soon to be released. This is his third bit. He was in SHU eight months ago, and came to ICP from the Box. He had no money, he was borrowing cigarettes, he told a CO that he wanted to go to PC, he had a razor, and then found himself in the Box (in observation on the way? - he's not sure). He is prescribed Depacote, 2,000 mg. per day, Risperdal, one pill in the evening, and Cogentin. He likes

the groups in ICP. He had no psychiatric history prior to incarceration. He does not get any visits, his mother does not know how to get to the prison. He remains in ICP, does not go to see the doctor, and is afraid of guys he owes money. He has done some drug treatment in ICP. Being in SHU is extremely traumatic for him because there are "gangsters in there" who threaten him. He perseverates about cigarettes and owing money, and he is very frightened of population yard. He says he is Bipolar, meaning "I swing on people," he goes on to report he "acts dumb, gets 'crazy,' and gets paranoid." He also gets depressed and he hears voices – the television or other people talking to him when nobody is there. He says his mental illness gets much worse in SHU and in observation. And when he is in SHU or PC mental health staff talk to him only at cell-front. Mental Status exam reflects borderline or low intelligence, smiling that is sometimes inappropriate, expresses guilt about killing a worm while fishing, stares and halts the conversation reflecting thought blocking and psychotic autism, and there is concreteness and psychomotor retardation. He had been at CNYPC for a few months prior to coming to ICP. He says that PC is the same as SHU, except in PC prisoners can watch more television and eat together. His clinical chart is consistent with the history he presents. His dx is Schizoaffective, previously Schizophrenia. He is prescribed anti-psychotic and mood-stabilizing meds (including, at various times, Haldol, Risperdal, Depacote, etc.) He has been on Haldol Decanoate because compliance has been a problem. This man suffers from chronic serious mental illness, is relatively stable in ICP but probably needs PC if he is not in ICP.

Example of:

SMI (Schizoaffective or Schizophrenia) in ICP

Has been in SHU and not done well there

Finds PC same as SHU

(Interviewed while housed in ICP).

O.C. has been in prison for 15 years, for committing his first felony. He had been a merchant seaman. He has syphilis and TB. He has been in ICP since November, 2002, and was in Five Points ICP before that. He has been in ICP for his entire term. He has large memory and cognitive problems, and cannot function without help. He takes medications, some psychiatric but he does not remember which ones, and he takes medication for Vertigo. He feels other prisoners take advantage of him, and he has had a few fights. He cannot function in general population – there is too much going on, and too much victimization. He spends his time reading. His out date is August, 2003, and he plans to get a room in a residence for merchant marines. He has been in SHU twice. He used to hear voices, but no longer. He was at CNYPC once, in 1993 or 1994. On mental status this man is pleasant and talkative, but there are obvious cognitive deficits and large memory gaps with noticeable confusion. His clinical chart is consistent with the history he presents. He carries a diagnosis Dementia NOS. He has been tried on anti-psychotic medications, and on various antidepressants. He is obviously incapacitated by organic brain disorder, with intermittent psychosis. He seems to manage in ICP.

Example of:
Dementia/ Organic Brain Syndrome in ICP
Intermittent psychosis

Clinton Correctional Institution – 7/15-7/16/03

A.C.

A.C. speaks very little English, and this interviewer speaks a little Spanish, so this was a brief interview. He has been in prison for most of 25 years. He is currently serving time for a new commitment for violent crimes. He has a life sentence. He has a history of depression, and his chart reflects OMH treatment during the 1990s. He was discontinued from the OMH caseload in June, 1999. His clinical record contains reports of depressive episodes in Jan. and again in Oct, 1999, while he was in SHU – depressed, not eating, mute, sent to RCTP or PSU at Great Meadow for crisis, sent to CNYPC and was refused admission, on and off antidepressants, returned to SHU each time, discharged from OMH caseload with diagnoses Adjustment Disorder With Depressed Features or Depression NOS.

Example of:
Significant Depression
Discharge from OMH caseload
Spends much time in SHU

K.H.

K.H. has been in prison for three and a half years. He is currently in KeepLock in ICP and/or PC. In April, 2003, he ingested 1600 mg. Seroquel as a suicide attempt, and a few days later assaulted an officer. He was sent to CNYPC and while there barricaded himself in a room. At CNYPC he was diagnosed "no mental illness" and his medications were discontinued. It was then that he barricaded himself. He has spent much time in SHU, has received tickets for self-mutilation, and has been to CNYPC twice. When he is in the Box, the voices he hears get worse, has the paranoid idea that the officers are out to get him, gets terrified, and is driven to cut himself. His concentration is poor in the Box, and his voices and suicide ideation become much worse. Then he gets tickets for self-harm. He becomes confused and disoriented as to place and time, and there are no newspapers to help him orient himself. He has been hearing voices since the age of 15, and he has been prescribed Depacote in the past. He does not see anyone from mental health at Clinton. On mental health status he stares intensely, is concrete and flat, and presents credible history of auditory hallucinations. Two months prior to our interview he was diagnosed no mental health problem and his medications were discontinued at CNYPC. He is supposed to see mental health staff every other month, but it does not happen. He wants mental health treatment, and is on Level 1. His mother died when he was six, his father "gave me away," he grew up in group homes and he went to the ninth grade in school. He has not earned a GED. He began cutting

himself in group homes. He has cut himself quite a lot while in SHU, and has scars on his arms and legs. He reports that "cutting" relieves his anxiety, he gets a rush, and then he feels better. His clinical chart is consistent with his history. His diagnosis on 8/16/00 is Schizophrenic Disorder, a core history lists diagnosis Schizoaffective Disorder; he has been admitted to CNYPC twice since beginning this term in August, 2000, the last in September, 2002. He was prescribed Seroquel 200 mg. h.s. and Paxil 20 mg./day through 2001. He still was prescribed these medications (actually 300 mg. Seroquel) in SHU at Midstate as of 5/21/02. Through 4/9/03, he still carried an Axis I diagnosis and was receiving medications and outpatient treatment at Elmira, and cycled several times to observation for suicidal thoughts and/or behaviors.

Example of:

SMI in SHU

Cuts/self-harm and receives tickets for that

Un-diagnosis and discharge from OMH

Deterioration in SHU

Tickets in SHU related to deterioration, more time in SHU

C.C.G.

C.C.G. has been doing 17 years on a parole violation. He has been in and out of SHU since 1994, and in the Box for a year on this sentence. When he is in the Box he receives more tickets than when he is elsewhere in the prison. He has not been to CNYPC. He has been to observation three or four times, usually when he threatens suicide. He does not feel that staff take seriously prisoners' suicidal thoughts. He has not taken psychiatric medications, and had no prior psychiatric history when he first went to SHU. Mental health contact is limited to cell-front interviews. On mental status this man seems inappropriate, for example smiling at the wrong time. His thought process is delusional, especially when he begins talking about female attorneys. He attempted suicide in KeepLock nine months ago; he says he did so because he told a CO he was having trouble and nobody did anything. The psychiatrist, Dr. Menendez, does not do rounds in SHU. A review of this man's clinical chart reveals a 12/12/01 nursing assessment recommending referral to CNYPC for self-harm statements, and a treatment recommendation: "Transfer to OBS for psych. Eval., stabilize and return to SHU."

Example of:

SMI (psychosis) in SHU

Deterioration and more tickets in SHU

No real mental health treatment

Cycling from SHU to observation, less often to CNYPC

D.N.

(Interviewed while housed in General Population).

D.N. began his fifth prison term on 1/14/03. He was admitted to Bellevue psych ward prior to incarcerations. He rates the mental health care very low, and says

that the psychiatrist, Dr. Menendez, is no help at all. He sees the psychiatrist every two months. He is prescribed Haldol, but it causes terrible side effects. Mental status examination reveals pressured and tangential speech, no eye contact, bizarre grimaces and lack of logical thinking. His clinical chart reflects a diagnosis of Schizophrenia and Mental Retardation with a GAF of 35. He has been in CNYPC and ICP. He insists that I read an affidavit he has prepared describing the abusive way he has been treated, and in the affidavit his thought process is clearly delusional, fragmented, incoherent and bizarre. In other words, this man is actively psychotic while in general population and taking medications. His thick chart contains diagnoses of Psychosis NOS and Schizophrenia, Undifferentiated. He has a WAIS IQ full scale of 65. He is prescribed Depakene, Haldol and Artane. Bellevue admission at 16 is noted. Prior Rx Seroquel 1200 mg. per day, Prolixin, Depakene 2000 mg. per day, another time he is on Haldol Decanoate 200 mg. per month, and so forth. He is admitted to observation or CNYPC after non-complying with meds and decompensating. He is given a lot of time in Keeplock. He is seen every two months by the psychiatrist and is followed by a case manager.

**Example of:
SMI (Schizophrenia) in GP
Spends time in Keeplock**

E.E.O. (Interviewed while housed in SHU).

E.E.O. had been prescribed Zyprexa and diagnosed Bipolar Disorder until the previous April, when his diagnosis was downgraded to no diagnosis and the medications were stopped. He caught an outside case five months prior to our visit. He had a psychiatric history, including hospitalization, prior to incarceration. On mental status exam this man laughs inappropriately, has very disturbed memory and concentration, exhibits internal preoccupation, and demonstrates very loose associations. He is incoherent. He tells me he is a poet, and gets fan mail from Tupac (who is deceased). He rocks in his seat, probably self-stimulating. When asked if he is sad for missing his mother, he laughs energetically in total contrast to how he says he is feeling. Michael is his therapist, and visits with him only at cell-front. In summary, this occupant of SHU is floridly psychotic and not receiving OMH treatment. His diagnosis has been changed to "no diagnosis." His clinical chart reflects the process of "un-diagnosing." He had been diagnosed SchizoAffective Disorder, and more recently "no diagnosis." History of psychiatric hospitalization at 15 noted in chart. Most SHU screening evaluations are skimpy and contain almost no information about signs and symptoms. In June, 2000, he tried to climb through the ceiling from the bathroom in the visiting room, but fell through the ceiling. It was noted he was acting in a bizarre fashion, but Dr. Langbart felt there was no mental health problem. A 10/01 screen reflects emotional problems and recommends further evaluation, and then a 10/18/01 RCTP note reflects no mental health needs – he had been sent to observation for evaluation. But on 10/18/01 he is prescribed Zyprexa 10 mg. Per day, Lithium 900 mg., and emergency Haldol. 3/8/02 and 9/02 Adm/Screening forms diagnose Bipolar Disorder I, most recent episode Manic, with ASPD. This man is clearly suffering from SMI, but is retained in SHU without adequate

mental health treatment. His lack of cooperation is an issue, but on quite a few occasions notes in his chart reflect serious mental illness. He needs a thorough psychiatric assessment and it is likely that if he were placed in a treatment setting he would be more likely compliant with the treatment he urgently needs.

Example of:

Active psychosis in SHU

Un-diagnosis and no mental health treatment

Continues on medications

Deteriorates in SHU

E.Z.

(Interviewed while housed in SHU).

E.Z. has been in SHU for a year, and in prison for five years. He has another 11 months of SHU to do. He reports "they say I'm Schizoaffective." He stopped taking his medications five days prior to our interview, and reports he feels "speedy." He was sent to SHU for possessing a pipe, which he says he needed "to get an undercover (agent) prisoner." He says that in November of 2002, he was moved from SHU to APPU, which he describes as a high-profile protective custody unit. The officers told him that he's a dead man because it's a KKK unit. Fearing for his safety, he came out of his cell with a pipe, and that's when he was transferred back to SHU. He says he wrote notes at the time threatening "to take them down if I go." He has been at CNYPC twice during this prison term, on one of those admissions he was told he is Paranoid Schizophrenic. The last time he was at CNYPC for two months, and then returned to SHU. He has been a problem drinker for many years. He tells me both that the NYPD killed his wife in 2000 while arresting him, and that months later she was thrown in front of a train, and he does not recognize a contradiction between these two stories. He is prescribed Geodon 80 mg. per day, Trazadone 100 mg. at night, and Vistaril 150 mg. per day. In the past, at Clinton, he has been given involuntary injections of Haldol. He talks to Mike, the therapist, at cell-front in SHU, and sees Dr. Menendez every other month. He works on being able to control himself, and he believes he should be sent to Sullivan to the Special Needs Unit. He does not think he can survive in general population because he has enemies. He has made suicide attempts. He worries about the medications because they slow him down and if he is released from segregation, he will not be able to take care of himself. On mental status exam there is some pressured speech, and agitation. His clinical chart is consistent with the history he presents. He was admitted to CNYPC twice in 2002 for a couple of months each time. On 4/24/03 he was prescribed Vistaril 75 mg. b.i.d., Geodon 80 mg. p.m., and Trazadone 100 mg. h.s. He has a pre-incarceration history of psychiatric hospital admissions, and at least three admissions to CNYPC in the 1990's. On 7/6/02 he is in observation and it is noted he has tried to "hang up" three times in the past year. There are many notes throughout his chart about pressured speech and grandiosity. There are discussions about whether he is delusional, claiming elaborate plots against him, or he is merely suffering from Axis II problems. He is sent to observation for suicide threat on several occasions. On 4/24/02, a nursing progress note reflects "**E.Z.** was found by the night shift in the SHU to have a

sheet around his neck. He told me that 'the FBI and some other people planned to have the Black people kill him when he left the SHU.' He planned to 'kill himself before they do it to me.'" He was placed on a 1:1 watch in the SHU that night. There are many other notes reflecting possibly delusional ideas. Other medications have been prescribed, including phenothiazines. This man is clearly delusional and psychotic, and is suffering in silence in SHU while OMH tries to make up their minds whether he has an Axis I diagnosis. His mental condition is deteriorating in SHU.

Example of:

SMI (probably Schizoaffective) in SHU

Cycle to observation, CNYPC, and then back to SHU

Protection issues intertwined with delusions

D.P.K.

(Interviewed while housed in D Block SHU).

D.P.K. reports he was seen by Dr. Menendez on 1/2/03 and involuntarily injected with Haldol because he was "acting violently." He charges racism, noting that prisoners are regularly beaten when taken to observation, this occurs more often if the prisoner is Black, and there are no Black officers nor Black mental health nor nursing staff. He describes in detail being carried to observation and having his clothing cut off. He was last in observation in January. He has not been admitted to CNYPC, though he says he was there "for a few hours" (for an evaluation?). He is in SHU on a 90-day ticket, and spends his time playing chess, reading the Koran and working out – trying to sustain his sanity. On mental status exam, this man wears glasses and has a beard; he is dressed in a red shirt, exhibits insistence verging on pressured speech, seems intense, obsessive and oppositional, does not aver hallucinations and is not certain whether he suffers from a mental illness, but he is certain he is "not normal." He appears to have ideas of reference and asks attorney Sarah Kerr if she is a stenographer. He says he feels pressure, he is isolated and lonely, and he feels depressed a significant amount of the time. He believes his depression is worse because he cannot contact his family and feels abandoned. He says he will not seek mental health treatment for his depression because of the awful experience he had in observation. His thin clinical chart contains mention of history of paranoia and flat or depressed affect plus treatment by CNYPC during a previous bit, but screenings this bit are repeatedly unremarkable and recommend no mh services. A 10/19/90 observation note reflects "laughing, crying, screaming, throwing things." He intermittently is seen by OMH, and notes reflect some paranoia, phobia, and repeatedly depression, but no mental health services either wanted or felt by staff to be needed. An 11/31/01 Admission/Screening Form contains diagnosis Mood Disorder NOS. Mental Health Level is 4, 3, or, but on 1/2/01, it is 1. He has been in and out of "the box," and OMH repeatedly is ambivalent about his mental state and need for treatment – they recognize "agitation" or "depression" or "phobia." He has been to observation several times, but he is soon discharged from treatment and receives no psychiatric medications. An example is a 1/23/97 Outpatient Screening/Admission note, which states: "appearance: distrustful, suspicious; Emotion: angry, volatile, inappropriate affect, smiling when expressing anger; Speech: pressured, circumstantial; thought:

paranoid, grandiose, entitled. No hallucinations; Insight: impaired by his agitation." He is diagnosed Psychosis NOS with ASPD, and he is placed on Special Watch. He spent several days in RCTP, and was prescribed Prozac and minor tranquilizers. Other notes reflect no mh problem, and diagnose Conduct Disorder. Then he spends more time in SHU, as at time of our interview. In summary, this man seems moderately disturbed with an atypical clinical picture. He is paranoid and does not want mental health services. He likely suffers significant mental illness and disability alone in a SHU cell.

SMI (atypical psychosis) in SHU

Reports rough treatment when taken to observation

Under-diagnosed

Involuntary Medication on urgent basis while in SHU

N.O.

(Interviewed while housed in D Block SHU).

N.O. received SSI disability on psychiatric grounds since 1986, and entered CDC in 1994 (he may mean jail – he has a 95 ID No.) He was prescribed Mellaril, Haldol, Cogentin and Valium prior to incarceration, he was admitted to the psych. ward at Kings County Hospital, and he suffered from EPS (extrapyramidal syndrome, a Parkinson-like neurological problem caused by phenothiazines), but he has not been in mental health treatment in DOCS. He spent six months in the Box at Upstate, and he did 30 days Keeplock at Clinton. He has not been to observation and has not been admitted to CNYPC. He has only a few disciplinary tickets, and the ones that resulted in his SHU term had to do with refusing to program. He has attempted suicide by overdose twice, once at age 24 and once at Kings County Hospital. He reports he heard voices telling him to jump out of the window. This is his first prison term. He took hallucinogenic drugs prior to incarceration. OMH does not see him. He currently feels anxious and suffers from insomnia. He has not found mental health treatment helpful in other settings, so he has not participated nor requested it. On mental status, his flat affect, concreteness and akinesia, along with his history, suggest chronic Schizophrenia. His thin clinical chart contains no diagnosis, but OMH screening on 8/1/95 notes history of several inpatient hospitalizations and SSI disability. SHU mh evals contain almost no info, and he has not been on OMH caseload. He appears to suffer from SMI, and is being ignored while he remains in SHU.

Example of:

SMI (probably chronic Schizophrenia) in SHU

Missed on screening, no mental health services

G.S.

(Interviewed while housed in observation).

G.S. was seen in observation while awaiting transportation to CNYPC where he is being admitted. He reports having mental health problems since 1982. He was in ICP prior to observation. On mental status exam he exhibits pressured speech. He spent 15 months in SHU at Attica prior to being transferred to ICP at Clinton in 2001.

On mental status exam he seems to have ideas of reference and is somewhat agitated. His clinical chart is consistent with the history he presents. He has a long history of serious psychiatric illness and the prescription of anti-psychotic medications. He is diagnosed Schizoaffective Disorder or Bipolar Disorder, and prescribed Depacote, Haldol (oral and I.M.), Zyprexa, Klonopin. He was admitted to CNYPC multiple times in the late 1990's. Yet he was given a long SHU term. In June, 2001 he was tried in STP without success, and then he was referred to ICP in 7/01.

Example of:

SMI (Schizoaffective or Bipolar) was in SHU for a long time

Eventually transfer to ICP

Current acute episode, in Observ awaiting CNYPC transfer

U.T.

(Interviewed while housed in Meryl Cooper program).

U.T. has been in the Meryl Cooper program for one year. He has been in prison for four years, his first term. He is prescribed Depacote and Zyprexa, and has been seeing Dr. Melendez and taking medications for over a year. He had been on and off medications his whole life prior to incarceration. He applied to be in Meryl Cooper, but now feels the program is not for him. On mental status exam he has scars on his forehead, a shaved head, tattoos on his forearm. His speech is slow and deliberate and his affect is flat. He admits to poor memory and slowed learning. He went to the ninth grade in Special Education. He used drugs as a teen. He had head injuries growing up and describes himself as "klutzy." He went through a plate glass window in 1998, but has no memory of the event. He was admitted to CNYPC from jail because he smashed his head against the wall in a suicide attempt. He finds the Meryl Cooper program too difficult for him, with his limited cognitive ability, and he cannot progress with the phases of the program. He sees the therapist, Mike, and has requested a transfer out. He came here from a medium security facility, Oneida. His clinical chart contains the diagnosis Depressive Disorder, in 6/02 he was prescribed Paxil and Zyprexa. He is Mental Health Level 3. In 6/03 he was on Depakote. The chart does not reflect limited intelligence, nor head injury, nor problems with phase progression due to intellectual functioning. This man seems to suffer from a combination of closed head injury with organic disorder, limited intelligence and a functional mental illness.

Example of:

SMI, MR & Organic Disorder in Meryl Cooper program

Has special needs

Cannot progress in phase program due to intellectual deficit

Prisoner

F.F.V.

(Interviewed while housed in APPU).

F.F.V. entered DOCS in April, 2001 for the first time. He is housed in the APPU per his request, for protection. He had been assaulted by another prisoner at Auburn. He tells me he suffers from an anxiety disorder as well as hypertension, asthma,

and heart problems. He complains that the medical care is quite poor, and this increases his anxiety. He describes "panic attacks" where his heart rate speeds up and he feels palpitations. He is prescribed an antidepressant. He became very anxious when he was in a "strip cell" (observation) at Auburn CI for three days. He reports brief sessions with Dr. Melendez, the psychiatrist, and occasional talks with therapist, Keith. This prisoner's chart confirms he entered the DOC on 4/9/01. He had little in the way of prior psychiatric history. He has been rated Mental Health Level 3 much of the time, with one 4 in May, 2001 at Attica. There is a diagnosis Major Depressive Disorder, Recurrent and Moderate on Admission Screening (6/1/01). He was admitted to the OMH Satellite Unit on 9/24/01 after threatening self-harm. He has been prescribed Prozac 20 mg/day (7/12/01), Zoloft 150 mg./day, Effexor 150 mg. b.i.d. There are notes in his chart about coronary artery disease, hypertension, diabetes, degenerative joint disease and other medical conditions. He was admitted to the APPU on 6/10/03. He seems to be compliant with treatment and to have little if any disciplinary problems once he is in a safe setting.

Example of:

SMI (Major Depressive Disorder/Anxiety w medical conditions) in APPU

Requires protection, does OK in protection

Poor medical care increases anxiety

P.M.

(Interviewed while housed in General Population).

P.M. cannot remember his DIN number. He thinks he is prescribed Zyprexa, 20 mg., Cogentin, 1 mg. and Trazadone, 100 mg. He exhibits obvious tardive dyskinesia. He seems intellectually impaired, and shares that he was in Special Education. He feels the mental health treatment is OK. He had an auto accident that caused damage to his brain. He was on SSI in the community. He hears voices say mean things to him, they used to tell him to kill himself. Sometimes he cries and falls apart, obsessing about the loss of his parents. He is on the list to go to RSAP drug program, but he has been on the list since he arrived at this prison and they are very backed up. He gets into trouble for talking to himself in the hallway. He does not get tickets, but he is scared he will. He has been at Clinton for three months, and has an extensive psychiatric history with admissions to many hospitals. His clinical chart contains a diagnosis of Schizophrenia, Paranoid type. On 1/10/03 he was admitted to RCTP and then to CNYPC (only admission) with a Mental Health Level 1. He is prescribed Zyprexa, 20 mg., Cogentin, Trazadone 100 mg. and Seroquel 100 mg. OMH treatment plan is to see him two to three times per month for ten to 15 minutes, continue medications and encourage to take part in programs. He is coping in max GP with OMH outpatient treatment.

Example of:

SMI (Schizophrenia) in Max GP

Organic Brain Disorder

Coping in GP with medications and outpatient mental health care

J.T.

(Interviewed while housed in SHU or Keeplock status).

J.T. has been in prison for 14 years, and came to Clinton in 2002. He is in SHU (or Keeplock status) for assault on an officer, and has a seven month SHU term. He has asthma, which he says gets much worse in segregation, and he is afraid he cannot get adequate medical care in segregation. He has been treated by OMH since 1992 for Bipolar Disorder, and is now prescribed Seroquel 250 mg. per day. He says nobody in segregation is prescribed Depacote or any other mood stabilizer. He worries a lot and gets very depressed. He does not hear voices, has not been admitted to CNYPC nor to observation. He earned a GED in prison and was never on SSI on the street. He says he has traumatic stress disorder, which they call Schizophrenia. He has been in the RSAP drug treatment program, and needs to take it again but there is a long wait to get in. On mental status exam, this man is very intense with a flat stare, there are tangential thoughts and bizarreness consistent with Schizophrenia. I suspect he experiences delusions and hallucinations, in spite of his denials. His chart is consistent with his history. He had pre-incarceration psychiatric admissions for Schizophrenia, at least three times at Bellevue. He was homeless on the streets. His diagnosis is Schizophrenia, Paranoid type. He is prescribed anti-psychotic meds, most recently Seroquel 400 mg. per day. He is not admitted to CNYPC but has been in observation several times, usually for decompensation after non-complying with treatment. He is periodically dropped from OMH caseload due to refusal – this may be related to his losing control and getting tickets.

Example of:

SMI (Schizophrenia) in SHU

Not treated adequately

Asthma worse in SHU

Upstate Correctional Facility – 7/17 – 7/18/03

K.Z.

(Interviewed while housed in SHU).

K.Z. has been in prison for 12 years. He has been in SHU since 1993, and at Upstate for three months. He explains he gets in trouble with COs. When he was at Southport, attorneys from PLS tried to arrange for him to have a neurological examination, but that never happened. He has a history of lead poisoning as a child; he dropped out of school in the tenth grade. He says he thinks he has memory problems because he fell a lot as a kid. He became depressed and tried to hurt himself at Southport. He does not hear voices; he has not been at CNYPC. He was in observation a few times at Attica and Clinton. When he throws at staff, he loses control and doesn't know what

he is doing. Being in the Box causes him to get angry and lose control. He feels if he had received mental health treatment when he first came to prison he would not have gotten tickets. He cannot control his temper, and the problem is much worse when he is in segregation. He is single-celled at Upstate and sees mental health. He sees the psychiatrist only rarely, and was told last time he asked to see him that he would have to wait three weeks. He stopped his medications a few days ago, because they caused nausea and he had to go to the hospital, but then they started the medications again. He tries to study in his cell but has limited ability. He saw the telemedicine doctor once. He has been ticket-free for a while because he reads the Bible. His mom visits him once per month from NYC. On mental status, he seems intellectually impaired, very sweet, smiles inappropriately, has slurred speech, seems childish. He clearly suffers from Developmental Disability along with mental illness and a probable organic brain disorder, and he needs a protective environment such as the SNU or possibly an ICP.

On his clinical chart, there are diagnoses of Bipolar Disorder and Impulse Control problems in Oct, 2001. A 9/12/02 note re Neuropsych testing, in SHU, reflects his refusal to take tests and no more attempts will be made to test him. A history of head trauma is noted. He is prescribed Neurontin since 4/1/03 (1200 mg./day), Depacote, Remeron, Zyprexa and Benadryl. His Mental Health Level was changed from 6 to 3 on 7/11/01, and then to 2 on 8/15/01 at Shawangunk CF, "due to increasing impulsivity and refusing to communicate with staff." On 10/10/01 his diagnosis was changed from Impulse Control Disorder to "Bipolar Disorder NOS with suspected Organicity." But on 6/13/02 he is transferred to Elmira SHU as a Mental Health Level 1, and on 3/11/003 he is transferred to Upstate as a MH Level 3(?) A 12/19/01 treatment plan review at Elmira (SHU) states he "has continued to make threats, openly masturbate in the presence of female staff. Patient also has a history of head trauma and may warrant neuropsychological testing as soon as can be arranged.... He states 'I have 2 personalities. I get aggressive with something evil'." The neuropsychological testing did not happen because he refused, he continues to be seen by OMH at cell-front. It is noted that he has sustained head traumas, and then the treatment plan review states: "Rehabilitation and Social Supports are minimal due to SHU status." But then, instead of doing something about that, e.g. moving him to ICP or even STP (he is refused from STP at Five Points, reasons unclear), he is sent to Upstate where there are even less services – and his Mental Health Level is changed to 3 (without any evidence of improvement in his mental state.)

Example of:

SMI and Mental Retardation and Organicity in SHU

Inadequately diagnosed

Mental Health level changed as he is transferred to Upstate

Deteriorates in SHU

C.C.Y.

(Interviewed while housed in SHU).

C.C.Y. entered Upstate in 2000 and is single-celled. He feels "this place is OK except the COs mess with me and I lose my temper." He sees Mr. Kim, the mental health

worker, once a month for five to ten minutes in a room, and then sees the psychiatrist via telemedicine once every one to three months. He does not sleep well; the COs mess with him and then he loses his temper. He gets a lot of tickets, becomes suicidal, and has been sent to observation at Upstate. He believes the COs tell other prisoners to beat him up, and they do. He has substance abuse problems. He is prescribed Paxil, 40 mg. Per day, plus Trazadone 200 mg. hs and 100 mg. in the A.M. He is depressed and cries all day when he is not sleeping – but he sleeps a lot in the daytime. He does not read because he cannot concentrate. He was in Special Education in school but dropped out in the ninth grade. He has been having cognitive and memory problems since a serious car accident at age 37. He does not hear voices, but he is very depressed; he has sleep apnea, feels hopeless, criticizes himself a lot, and berates himself. He has been to observation at Upstate four or five times, and was sent to observation at Clinton for seven days without receiving any real treatment. He was considered developmentally disabled (MR) and was on SSI for psychiatric reasons prior to incarceration. He has also been admitted to psychiatric hospitals in the community, usually for serious suicidal acts. He says he loses control when he gets angry, and he gets angry a lot in segregation. He has not had drug treatment. He thinks he needs to be in a mental hospital. His clinical chart corroborates his history. He is given the diagnosis Depressive Disorder. On 4/18/01, his medications were Paxil 40 mg./day and Sinequan 100 mg. h.s. There is very little mention of DD or Mental Retardation in his chart, though he is noted to be obese, disheveled, and having a difficult time coping. He has several stays in observation at RCTP, and cycles to SHU or Keeplock. Some notes reflect the opinion that he suffers from no SMI, yet he remains on medications and continues to cycle to observation. Other notes clearly identify depression. This man has a drug abuse problem which remains untreated; he suffers from DD/MR as well as an Organic Brain Syndrome secondary to closed head injuries, and he suffers a functional serious mental illness (Depressive Disorder). Still he is at an institution that does not offer mental health treatment at the level of intensity required for his SMI and other conditions.

Example of:

SMI (severe Depression) with DD/MR at Upstate

Anger grows and is out of control, leading to more tickets

Cycles to observation and back to SHU

Inadequate treatment, sometimes downgraded diagnosis

Should not be at Upstate because of Mental Health Need

A.Y.

(Interviewed while housed in SHU).

B.Y. has been in prison since 1988 this bit, or for a total of 25 years as an adult. He has had a couple of strokes and limps. He came to Upstate in April, and has a 150 day SHU term. He is single-celled because of a violent felony. He has two college degrees. On mental status exam it is obvious he has serious memory problems. He has never been admitted to CNYPC but has been in observation at Upstate. He has taken medications for depression, suicidality, hallucinations and diabetes – but he cannot remember which medications. He sees things. He believes mental health staff see him as

depressed and suicidal, with hallucinations. He feels confused about things, possibly because of the strokes. He sees a dead person in his cell, and talks to him. He feels the staff at Upstate are very mean, and beat the prisoners. He cannot get a wheelchair, though he believes he needs one. He is prescribed Sinequan via telemedicine, and sees the therapist only occasionally. He was refused admission to STP when he was at Five Points. He believes that time in the Box causes his anger to mount and then he gets more tickets.

Example of:

Combined SMI (Depression, possible psychosis) and Medical/Stroke Condition

In SHU at Upstate

Inadequate treatment, inadequate disability rehab and support

B.Y.

(Interviewed while housed in SHU).

B.Y. who wears a neck brace, has been in prison for 16 years and in SHU off and on for six years. He describes mental health care within the DOCS as "garbage." He has taken medication for delusions in the past – Zyprexa – but not now because he refuses to take it. He has been admitted to CNYPC three times between 1996 and 1997, and was sent to observation numerous times at Comstock. He exhibits delusional thinking about a sinus condition, and he believes "they think I'm suicidal because I complain about my sinuses." He says the brace on his neck resulted from an assault by officers in 1998. He is single-celled. He is bringing a lawsuit because "they say I'm delusional when it's really a physical problem." On mental status exam, this man does seem bizarre and delusional; he perseverates about his sinus condition in a delusional fashion - but he does not want mental health treatment. Still, this is no reason to discharge a clearly psychotic individual from the OMH caseload and send him to an institution where he cannot receive mental health attention. His clinical chart is consistent with the history he presents. In 1997, 1998, he was admitted to CNYPC with Delusional Disorder, with no known psychiatric history prior to incarceration. He was discharged from CNYPC with diagnosis Adjustment Disorder and no meds. He has been seen by OMH off and on since, but no consistent treatment, and he spends time in SHU. In other words, he is suffering serious mental illness alone in his cell and is not receiving adequate mental health care.

Example of:

SMI (Delusional Disorder) in SHU

At Upstate, where there are insufficient mh services

Discharged from OMH caseload for non-compliance

Cycled from to observation, CNYPC (in past)

W.L.

(Interviewed while housed in SHU).

W.L. has been in prison for three years, and in SHU for 22 months, nine of them at Upstate. He has been treated for depression throughout his prison tenure. He

complains about officers' insensitivity – e.g., after he was placed in a cell with a prisoner he could not get along with, they got into a fight, and then the officers beat him up and gave him a ticket. He cannot read in SHU because he is unable to focus and concentrate, so he lays on his bunk most of his waking hours, looking at the ceiling and having too low energy to do anything else. He withdraws, isolates himself, cries a lot, and many days does not even get out of his bunk. He has not been admitted to CNYPC and has not been in observation. He is prescribed Zoloft and Benadryl. He had attended college and worked prior to incarceration. His mother is a CO at Rikers Island. His girlfriend comes to visit him. This man suffers from Major Depressive Disorder and is taking antidepressants. His chart contains a diagnosis of Depression NOS, and admission to OMH OP services on 9/20/02. Progress notes reflect stress due to a sense it is unfair that he is incarcerated, and sadness about separation from family and his child. He is offered relaxation techniques, etc.

Example of:

**SMI (Depression) in SHU, at Upstate where mh services are lacking
Deteriorates, worse depression, in SHU**

H.E.

(Interviewed while housed in SHU).

H.E. is doing one to three and is hoping for release in September. He says he was a police officer. He is prescribed Paxil and a tranquilizer; he was taking Neurontin and Seroquel when he entered jail. He has ten tickets for smoking and complains there is no place to smoke. He says he never sleeps, until he "crashes" from exhaustion. He stopped taking psychiatric medications at Downstate. He has much anxiety and a history of hearing voices. He also experiences depressive spells and severe mood swings. He receives mental health care via telemedicine, which he likes. He gets agitated in the Box. From 1992 until he came into prison he was prescribed Paxil, Neurontin, Seroquel and Effexor. He has seen the mental health staff at Upstate twice in the four months he has been here. He was on methadone for many years, but does not have a drug problem in prison. On mental status exam this man is obviously in a manic episode, and with his history he is suffering from Bipolar Disorder. His clinical chart reflects repeated admissions and discharges from OMH caseload, but in 10/03 he was prescribed Paxil prn (sic?! – this is definitely the wrong treatment for someone with Bipolar Disorder, since it tends to precipitate a manic episode) for "Anxiety Disorder/Panic attacks." OMH does not question credibility of symptoms, but under-diagnoses as Anxiety and treats with Paxil while at Upstate. This man needs to be on psychiatric medications and needs to be transferred to a more intensive treatment setting. By history, his agitation is worse in the Box.

Example of:

SMI (Bipolar Disorder in manic phase) in SHU at Upstate

Currently in Manic episode, not discovered by OMH

Not receiving assessment and treatment he needs

S.H.

(Interviewed while housed in SHU).

S.H. has been in prison (jail?) since 1993, and has been at Upstate for three years. He says the officers abuse the prisoners here, write tickets, and tamper with your food. He sees the mental health counselor through the food slot of his cell door. He has been forced to take medications on account of his aggression. He was admitted to CNYPC three times in the late 1980's. He does not like being double-celled because there is no privacy. He does not have a behavior problem when he is not in segregation, but in seg he cannot control his anger and he gets into cell fights. He is in the Box for smoking pot; he has no prior SHU time. But he has received between seven and nine tickets since coming to this box, one for refusing to move, one for fighting, etc. "You get tickets because you feel oppressed and you're forced to do things against nature. That takes you out of your comfort zone, then they put another prisoner in your cell and he comes at you from a different place - I can't deal with all the pressures." He feels the COs abuse their authority. "Anger builds, you go into emotional overload." He has a lot of trouble getting along with cell-mates. He has learned to cope. Sometimes he gets into trouble with a cell-mate because he does not want to go into personal stuff with him. He is proud of himself for maintaining his sanity throughout this ordeal. On mental status examination he is angry but coherent; his history is credible.

Example of:

Not in mental health treatment currently

History of admission to CNYPC three times in the 1980s

Anger builds up in SHU

A.O.

(Interviewed while housed in Keeplock).

A.O. has been in DOCS since May, 2001, on his second bit. He had a five year prior term. He has been at Upstate for two months, having transferred from Southport SHU. He does not know why he was sent here. He believes it might have to do with his attempting suicide, which was triggered by retaliation against him by staff who thought his family was making threats. He knows his food is being tampered with because he has an ulcer. He believes his SHU time has expired and he is on Keeplock(?) He made a suicide attempt prior to his hearing. He has made two significant suicide attempts in prison. He has a life sentence, but he is evidently appealing, and he claims staff threw away his legal mail. His first suicide attempt was by OD at Wende; he was stripped in observation for a week and received no treatment except group interviews by mental health staff with COs present. He asked to be returned to his cell because he felt he was not getting treated. He feels he is suffering a lot being cooped up at Upstate. For example, he is no longer doing SHU time, and he should be having privileges restored

while he is on Keeplock – but he isn't because he is here – he does not get visits, and he should. There is no mental health care here – it's a joke. He had no prior psychiatric history, he has never been admitted to CNYPC. He thinks he is depressed and suicidal, and it's related to having his chances of reversing his conviction unfairly ruined. He feels like he is treated like a beast here. His symptoms include sadness, crying, self-castigation, psychomotor retardation, no motivation to do anything – e.g. he has started but not finished many letters – and he gets angry easily. He is single-celled because of his sentence. This man is depressed and not receiving adequate mental health care. He is single-celled, but he needs out-of-cell programming. He says he is on Keeplock status, so he should have more privileges. His chart contains the diagnosis Depressive Disorder and Adjustment Disorder with Mixed Features, several stints in observation, sometimes lengthy, a 9/4/03 note reflecting phone call from grandmother telling staff she'd received a letter where he says he is going to kill himself. He is sent to observation. He cycles from observation to SHU and back to observation. As of 1/04, his Vistaril was discontinued and he was prescribed Remeron 30 mg./day.

Example of:

SMI (depression) in SHU

Confusion re SHU vs. Keeplock term

Depression aggravated by segregation

Cycling from SHU to observation and back to SHU

C.K.

(Interviewed while housed in SHU).

C.K. entered prison in 1983, and came to Upstate in March, 2003. He has been in a wheelchair for 12 years with a T10 spinal lesion and paraplegia – he carries a bag. He was in PC at Greenhaven Hospital in 1992 when, he thinks, he had Guillian Barre or a tick bite. He was convicted of a sex crime, and he has been attacked in prison many times. He has not been well protected, even when in PC, and he was attacked even in his wheelchair at Greenhaven – his neck was cut. He received a six month sentence to SHU because he refused to program in PC because he felt unsafe. He later refused double-bunk for the same reason, and was given another ticket. He is in a single cell at Upstate, and is not receiving mental health care. He has not been admitted to CNYPC, but he was in observation a few times for suicidal acts early in his prison term. His thin clinical chart corroborates his history. He is given no psych diagnosis, and had been prescribed sleeping pills years earlier. This man is talkative, wheelchair-bound, and not suffering from SMI although he does experience a lot of pain and suffering.

Example of:

Disabled (wheelchair) in SHU

Protection issues lead to tickets

No known SMI, but seems depressed due to circumstances

S.G.

. (Interviewed while housed in SHU).

S.G. has been in prison since 2000 and at Upstate since 9/11/02. He tells me in a tearful, angry tone that he has no significant mental health treatment history, but he has been in a suicide cell three times in May. "The COs stand there and humiliate you, they take their anger out on you, it's the only place in the prison where there's no video camera. They turn the water off, I tried to hang up using ripped up pieces of my (Ferguson) gown, I did it to get water, I was desperate to get water!" And he adds that the CO came to see him when he was in observation and told him not to be surprised if all his property was destroyed when he got back to his cell. He had 33 tickets in May. He says, almost incoherently, that he went to the suicide cell three times because he was trying to get their attention in order to fix his wrong reputation. He is HIV+, is supposed to be taking a medication cocktail, but they don't give it to him and they say he is refusing to take it. He did refuse one time, but states that he wants to take it regularly. On mental status exam he is agitated, almost desperate in his attempts to be understood, he is markedly depressed and crying during the interview to the point of incoherence. He gets anxious and agitated when he is in the Box, the COs harass him, and he then gets desperate and tries to kill himself. He has received 40 tickets while in the Box. He has a SHU term that lasts until 2011, during which time he will not be permitted commissary and won't be able to use the phone. He believes officers are afraid of him because he is HIV+ and he is angry. He feels the COs blame him whenever other prisoners bang on their doors and make noise. He says he is a "paranoid person." He believes he was framed whenever he was alleged to have committed unhygienic acts. He seems earnest in his attempts to kill himself. He has been asking for four months to receive psychiatric medications, but they do not give him any. They say he refused psychiatric medications, he says that is not true. He is serving 25 years to life. In his clinical chart, he is admitted to CNYPC on 4/24/03 with diagnosis deferred. Depression is noted on 2/21/01. On 11/30/2000 he is seen by mental health cell-side and complains angrily about having to share a cell. On 1/11/01 he is prescribed Trazadone 100 mg. B.i.d. for depression, and on 1/13/01, mild mood disorder is noted at Five Points. SHU mental health evaluations often contain long notes, e.g. describing suicide ideation, trips to observation and cell-front conversations with mental health staff. This very emotional, labile man with HIV seems in a vicious cycle of accelerating behaviors that result in tickets and more negative attention. He is agitated and depressed, he does require psychiatric attention and is not getting much except for cell-front interviews, yet on notes from those interviews, OMH staff do see that he is having emotional problems.

Example of:

SMI (Depression) in SHU

Deterioration in SHU

Tickets – many – related to SMI

HIV+

Not getting treatment that is urgently needed

F.F.T. . (Interviewed while housed in SHU).

F.F.T. has been in prison for eight years and has four more years to serve. He has been at Upstate for 15 months and is on Level 3. He is prescribed Paxil, 20 mg. per day, plus a sleeping pill for the severe insomnia he experiences when he is in the Box. He gets anxious and claustrophobic in the Box; he feels his heart racing and sometimes hears voices, gets frantic thinking he cannot breathe. He states that his panic puts him in closer contact with officers and he hears chains rattling and thinks they are going to beat him, so he gets more anxious. The psychiatrist is giving him Paxil for precisely this problem. He never had anxiety nor panic in GP. In the Box he cannot concentrate, he has to read things over and over again in order to comprehend them. He says he is a spiritual person (he wears dreads that are woven around his head and he has a beard), but others think he is crazy because of his spiritual ideas. He was beaten by a cellmate, and he asked the cellmate if he was satisfied. He has visits, but not by his two children who are on Long Island. He sees the psychiatrist via telemedicine, once every three months for approximately eight minutes. He did the drug program, ASAT, for six months – but found it not very helpful. His clinical chart contains diagnoses Generalized Anxiety Disorder and Adjustment Disorder with mixed Depressed/Anxious mood. A 10/3/02 Treatment Plan contains a Problem List that includes anxiety, mild depression, paranoia and physical/sexual abuse victim. He is seen as an outpatient, mostly cell-front, in SHU, and prescribed Paxil and Vistaril. In summary, this depressed young man with panic disorder and severe insomnia is helped slightly by Paxil, but basically is very symptomatic and dysfunctional when he is in the Box.

Example of:

SMI (depression) in SHU

Many symptoms and marked deterioration in SHU

M.K. (Interviewed while housed in SHU).

M.K. has been in prison for three years and has been at Upstate for two weeks following a ticket for assault on an officer. He was implicated in a riot at Auburn 6/14/03, and was given six – seven months in the Box. He says, "This box is extreme, you don't have socks, the food is horrible, the portions are small, there's a lot of mental abuse, the staff play games with the food, they don't give you things you're supposed to get, there's name-calling and racial slurs, you're double-celled." He has no psychiatric history, has not been to CNYPC, is not on medications. He says he cannot sleep here, and he's up for several days. He has a son, looks forward to going home; he was in print shop and on the waiting list of ASAP, but is not any longer. He is afraid he will start to become aggressive toward others as others have become here. He says there's a lot of

depression in the box. He's seen a lot of guys go off on their bunkies or hang up. The staff is slow to respond. This man does not suffer from a serious mental illness.

Example of:

No SMI, in SHU

Symptoms of SHU confinement

R.N.

(Interviewed while housed in SHU).

This 21 year old man had a three year term and is currently in prison on parole violation. He has been at Upstate for 90 days for a dirty urine. He needs a single cell because he is on the OMH caseload. He was at a Medium security prison, Mt. McGregor. He is seeing OMH because he gets claustrophobia and depression. He is not taking medication. He wants to see the psychiatrist and take medications, but he has been waiting a month on the list for telemedicine. He sees Dr. Kemp once a month in a room, but worries they are on camera. He is afraid that they'll retaliate against him for talking to us. All of his tickets have been for dirty urines. He was sent to prison at 16 for a drug-related robbery. He has been in ASAP, but didn't complete it. He has been depressed since he was eight years old. His parents fought a lot. He received a GED in prison and reads a lot, even in the Box. He has made many suicide attempts, he overdosed at ten or 11. He has never been to observation, nor to CNYPC, nor to a hospital on the outside. He thinks a lot about suicide, and feels very depressed being in the Box. He hopes to leave prison in 83 days and return to his family in Baltimore. This man is depressed, and is in prison and in the Box for turning in dirty urine.

Example of:

SMI (Depression) & substance abuse (Dual Diagnosis) in SHU

Depression worse in the Box

T.Q.

(Interviewed while housed in SHU).

T.Q. has been in prison since 1995, and had a prior bit going back to 1991. He has spent the majority of his prison time in the Box. I ask why and he says "It's the stress level, I lose my temper, I like staying to myself, I get into hassles with other prisoners." He does not have problems with the staff. He did a 26 day hunger strike at Comstock & Great Meadow because he believed they were messing with his food. He has had no tickets since November. He was on Zoloft for six or seven months by telemedicine, and liked it, but they discontinued it four months ago to see how he'd do. He says he needs something to help him relax, and he has sleep problems. He can go four days without sleeping. He does not hear voices, but he thinks he is "crazy." He has "bad nerves," his hands shake, he is jumpy and he can't sleep. Prior to incarceration, he was admitted to St. Lukes/Roosevelt Hospital psychiatry ward because he was psychotic for a couple of months after doing Angel Dust. He has a long psychiatric history, and has been behind bars off and on since age 15. He tried to hang up at Rikers Island in 1990, but he has not been to observation nor to CNYPC while in DOCS. He is more depressed

than ever now; he lost his mother in 2000 and his aunts and grandmother in recent years. He has not had a visit in four years. He has not received a GED, and has not been in a drug treatment program in prison. He talks to PJ in a room for six or seven minutes at a time, but has not done that in months. He has a cellmate, and has been involved in three cellie fights. Having a cellmate makes his depression worse. He does not think PJ is sincere. He thinks he needs psychiatric medications. He does not know anything about any 90 day evaluations. On his clinical chart he is diagnosed Adjustment Disorder (9/12/02), and then Depression (10/02), but on 5/18/01 he is terminated from OMH caseload. On 12/31/02 he is diagnosed Depressive Disorder NOS and is Mental Health Level 4. His SHU mental health evaluations seem superficial, sometimes reporting no depression, for example, even though by history and progress notes he is depressed at approximately the same time. Notes reflect mild to moderate depression, and he is seen at his cell-front and given in-cell course work by OMH. He is prescribed Zoloft for a diagnosis of Depression in Sept. and Oct., 2002, and is noted to be in psychotherapy related to the death of his mother. This man is clearly depressed, with a history of likely substance-induced psychosis prior to incarceration. He needs a single cell and mental health treatment – not available at Upstate.

Example of:

SMI (Depression, some psychosis) in SHU at Upstate

Inadequate treatment

Cell-front meetings with OMH

Screening mental health evaluations shoddy

Z.K. (Interviewed while housed in SHU).

Z.K. has been in prison for three years, and at Upstate since April, 2003. He has a 1 1/3 to 4 year sentence, but he "gets hit" at the Board for insubordination. He is OK with having a cellmate. He has been in the Box for so long that he is not focused. He had a "don't care" adolescent focus when he came to prison. He has not been to CNYPC, has not been to observation, and only sees mental health if there is a family problem. He has not had any visits since being at Upstate. He has knee problems and wants medical attention, but staff say there is nothing wrong with his knee.

Example of:

No known SMI in SHU

O.R. (Interviewed while housed in SHU).

O.R. has been in prison four years on his second bit. He came to Upstate in June, 2002. He is seeing mental health staff because he hears voices and is suicidal. He says he needs Prolixin and Cogentin. He has been prescribed Navane, Haldol and other medications in the past. He was admitted to several psychiatric hospitals prior to incarceration, including G Building (Psych) at Kings County Hospital with a diagnosis Major Depressive Disorder. When he stopped taking his psychiatric medications, he got

tickets. He succeeded at staying ticket-free at Clinton for 19 months, and then got into a fight, got cut, and received a ticket. He is depressed because he is afraid he will die in prison. He tries to get the staff to give him medications to keep him focused. On mental status exam he is very sad with psychomotor retardation. He is currently on Mental Health Level 2, but will be switched to Level 3. He also has black outs and gets rageful – the psychiatrist at Comstock says he needs a CAT scan. He is always sad, he lays in his cell and tries to sleep, he does not talk to anyone, he tries to avoid officers so he can stay out of trouble. He does not receive visits from his family. He was hearing voices until 2001. In SHU he has memory lapses and he goes into rages for no apparent reason. He is frightened by the rage that builds up when he is in segregation, for no real reason. He had a competency exam prior to trial. This man has had multiple head injuries as a child and used Angel Dust on the street. He has a long history of auditory hallucinations, memory lapses and rage episodes. His clinical chart contains a recent diagnosis of Adjustment Disorder with mixed features. Pre-incarceration psychiatric hospitalizations are noted. He was in observation at Clinton on 8/3/01 for “bizarre behavior and S/S of depression.” He was sent back to his SHU cell. An older Screening form, 10/8/99, has diagnosis Schizophrenia, Undifferentiated, at Clinton, and he was MH Level 2 and was prescribed Zyprexa up to 15 mg. per day. Mostly he is MH Level 3 to 6. He often tells mental health staff who visit him at cell-front that he is not having any problems, but one suspects denial. In summary, there is serious mental illness (not Adjustment Disorder) plus organic brain pathology, yet he is not being evaluated, he is not in treatment, and he is in an institution that lacks adequate mental health services for his level of pathology and dysfunction.

Example of:

SMI (Depression, Psychosis) at Upstate

Cannot control growing rage in seg

Inadequate Mental Health Treatment

Downgraded diagnosis

Cycling from SHU to observation and back to SHU

Great Meadow – 8/26 – 8/27/03

C.Q.

(Interviewed while housed in observation).

C.Q. has been in prison for seven years on this bit, and seems to have been homeless/living in a SRO hotel prior to that. He has been admitted to CNYPC twice, and prior to incarceration spent six months at St. Lawrence Psychiatric Hospital. He does not know why he is in observation; he knows he was getting confused and aggravated a lot and staff said he was not making sense. He has been in observation for several days and thinks he is being prescribed Zyprexa. On mental status exam he seems confused and incoherent with bizarre gestures and flat affect. He is relatively unresponsive to questions and thinking is tangential if not chaotic. He seems to be trying very hard to organize his thoughts, but with little success. He says he has trouble finding words. He was in GP, and says he gets along OK in GP. Prior to transfer to observation he was

seeing the psychiatrist once per month for up to 15 minutes in an office. He reports being suicidal in the past. He spent 30 days in the Box last year, and had a very rough time there. He has been admitted to CNYPC, evidently on more than one occasion, for six or nine days at a time. This man is clearly in a confusional state, most likely an acute psychotic episode but an acute brain disorder must be ruled out. He has spent several days in observation and has not recompensated. He reports he is being given anti-psychotic medications. In his clinical chart there is a diagnosis of Schizotypal Personality Disorder on 8/21/03. This is clearly a wrong diagnosis, one that is not true to the acute psychotic state I find him in now, and this is clearly not his first episode. His Treatment Plan of 9/16/03 states: "History of hospitalization, tends to become isolated with deterioration in personal hygiene while exhibiting bizarre behaviors." He had been managed in GP with occasional OMH intervention prior to the admission to observation during which I encountered him. But a note in his chart for the day after my interview, 8/27/03, reflects he is in the dorm, coherent and not confused. A day or two later he is returned to GP. He is sometimes on medication, Zyprexa 15 mg. per day, and sometimes he requests discontinuing it and is reported to do well, with minimal services. He was to be released soon after I saw him. He most likely suffers from chronic Schizophrenia, though the chart contains many lesser diagnoses, he does not cause trouble, he is sent to CNYPC or RCTP when he starts talking to himself, hitting himself and body odor accumulates. I think his symptoms are downplayed and he's someone who suffers in silence while being mostly ignored.

Example of:

SMI (probably Schizophrenia) in GP with OMH outpatient treatment

Under-diagnosed/psychosis downplayed but evident

Ongoing OMH treatment not intensive enough, given severity of condition

T.G.

(Interviewed while housed in observation).

T.G. has been in prison for two years and has one more to serve. He has been in observation for several days, having been transferred from Cocksackie where he was hearing voices commanding him to cut himself. He has been hearing voices for four years. He was already prescribed Zyprexa, but they increased his dosage. He also takes Paxil and/or Remeron. In observation he is seen only at cell-front for a few minutes, but today he was taken to an office, he thinks it was because we were coming. He has not been admitted to CNYPC. He believes they will send him back to Medium security at Green, but he fears that without more intensive help he will again become self-destructive. His daughter died recently, he was informed by letter, and this weighs on him. He has a lot of trouble managing in GP. He has been having depression and mental problems since 1992. He hears his father's voice when he is depressed, telling him to "get it over with" (i.e. suicide). He cut his neck three weeks ago, and has made multiple suicide attempts. He was in observation one other time, and says the mental health staff does not like to send anyone to CNYPC. He does not receive tickets for cutting himself. He assures us he is not manipulative, but truly earnest about killing himself. In summary, this man suffers from a Major Depressive Disorder, recurrent, with psychotic features

(credible command hallucinations ordering him to kill himself), and has been seriously depressed for four years, worse since his daughter's demise one month ago. He requires residential mental health treatment such as CNYPC or ICP, but he is certain he will be returned to GP at Green.

Example of:

SMI (Major Depressive Disorder) in GP in Medium Security Facility

Sent to observation at GM for acute psychotic decompensation and suicide crisis

Needs more intensive ongoing treatment

L.M.

(Interviewed while housed in dorm of RCTP).

L.M. had been in GP at Great Meadow and was told that his hygiene was poor and he needed to see the psychiatrist. He has been told they want him to stay and go to ICP. He is taking Zyprexa now, but was not at Great Meadow. He spent three months at CNYPC, returning to Great Meadow in January, 2003. He tells staff he does not want to take psychiatric medications. He has been admitted to CNYPC seven times; he would like to return to GP but believes they plan to send him to ICP. He was in the Box for three or four months at Attica. He has been seen by OMH since 1990. After he refused meds, OMH continues to see him and convince him to take meds, then his hygiene deteriorates and they send him to the mental health unit. He isolates himself. On mental status, his affect is flat, and he is very concrete. He seems to suffer from psychosis which is in partial remission after a recent decompensation.

Example of:

SMI (chronic psychosis) in GP at GM

Decompensated and sent to RCTP

Plan transfer to ICP

Has done time in SHU

D.I.

(Interviewed while housed in SHU).

D.I. has been in prison since 1994, and in SHU for seven years with many tickets accumulated in SHU. He does not know what the charges are; he believes they may be sexual, he feels the actions in question are not intentional but rather result from "tension." He has never been admitted to CNYPC. He has been in observation three or four times, but cannot remember when the last time was. He has taken psychiatric medications in the past, but not since he has been at this institution. He does see a mental health worker on a weekly basis in an office. He has not been in ICP. He reports that his emotional symptoms are much worse in the Box; he has nightmares and cannot control himself so he gets more tickets. He has a lot of trouble concentrating, repeatedly thinks of hurting himself, cannot control his mounting anger, and though he likes to read, he finds he cannot concentrate and finish reading anything. He believes that his mental illness causes dyscontrol of his anger, he consequently gets more tickets, and he has no hope of getting out of SHU prior to his release date in 2012. He writes sexual letters in

response to command hallucinations, and that is why he receives tickets. On mental status examination he describes credible auditory hallucinations including command hallucinations that often lead directly to tickets, complains of "frustration" and problems sleeping. His affect is inappropriate with smiling at inappropriate times and his thinking is disorganized but he tries to be responsive. He exhibits very strong First Rank Symptoms and his memory is grossly impaired. He repeatedly looks suspiciously around the visiting room. He went to the 11th grade in school, and his mother and sister visit him in prison. His chart is six inches thick. In it, he is diagnosed Impulse Control Dis. And ASPD and Paraphilia NOS. But on 6/10/97, he was given a diagnosis of Psychotic Disorder NOS. At that time, he was noted to be "seeing things, People came out of space ship,... being hyperverbal with bizarre acts, not aggressive...." His Mental Health Level was 1 on 11/8/01, and he was at CCF MH Unit for a crisis. He is repeatedly admitted to MH outpatient and then discharged, and noted to be uncooperative in treatment. In 11/01 he was noted to smear feces in SHU, and not to learn from mental health treatment nor from punishment. By 12/11/97 his treatment plan included "Pt. Will not utilize false reports of hallucination and delusions to cope with stress of SHU..." In other words, he was considered "Bad" and not "Mad" from that date onward, even though continual SHU confinement was causing serious psychiatric problems. A 2/8/02 Progress Note is typical for his chart. He was transferred from Clinton SHU to Observation for flooding the range, breaking up his cell and threatening to hurt himself. He reported command hallucinations preceding his bad behaviors. He is discharged back to SHU on 2/14. He is repeatedly observed for suicidal behavior, continues to get tickets in SHU, continues to "throw" and be placed behind Lexsan, makes inappropriate sexual statements and threats, and continues to be seen periodically by OMH staff at cell-front with a negative mental status reported - interspersed with notes about voices, suicidal, etc. He is intermittently prescribed Benadryl and minor tranquilizers or Trazadone. He is usually a MH Level 6. This man suffers from serious mental illness, likely psychosis, and his command hallucinations inform acts that repeatedly lead to tickets, but since this does not seem to be taken into serious consideration by staff and hearing officers, and he is mainly seen by OMH at cell-front and denies symptoms, he keeps accruing more time in SHU, mostly for sexual offenses that seem compulsive in nature, where his symptoms are aggravated. He is under-diagnosed, and his severe disability based on SMI ("Mad") is missed while his unacceptable behaviors are deemed "Bad" and reacted to with further tickets and more time in SHU, which, cyclically, worsens his mental dysfunction. He has never been treated in a mental health unit such as ICP, has never been admitted to CNYPC, and he deserves treatment and removal from SHU on account of unrelenting severe psychiatric problems.

Example of:

SMI (chronic psychosis with acute exacerbations) in SHU

Under-diagnosed

Not admitted to CNYPC because he is considered "Bad"

Inadequate treatment

Hallucinates alone in cell, gets tickets in SHU, condition worsens

M.O.

. (Interviewed while housed in General Population).

M.O. has been incarcerated for eight years on his second bit. He was admitted to CNYPC from Auburn once in 1999 when voices commanded him to throw excrement. The doctor had taken him off of his psychiatric medications, and he believes that's why he heard the voices he hadn't heard since being in jail. He had been on Depacote and Risperdal for six days at the time I interviewed him, but he said the voices have not disappeared. He links his voices in time with his violent outbursts. He has not received tickets recently, but has spent approximately three years in the Box for actions – spitting at an officer, flooding his cell – which he was commanded by voices to do. He believes that all three times he was charged with assaults on staff he was not taking his medications. He sees the psychiatrist once a month for ten minutes in an office. He has been to observation approximately nine times, usually for three or four days. His father died; he has no visitors. On mental status exam he seems a little silly and grandiose; he has tangential thoughts, exhibits ideas of reference, and has a fixed delusion about the government doing brain surgery on him. He says he wants people to think he is normal. He set fires and busted up his cell during his previous term. He says he used his time in the Box to meditate and study Black history. He has been essentially free of disciplinary tickets for two years, the two years he has not been in SHU – he thinks he learned about consequences of acts. He had a drug problem, and has been in RSAT, but feels the program did him little good. In summary, this man suffers from psychosis in partial remission on medications in GP. His chart reflects a history of fire setting. He began receiving mental health treatment in prison in 1996. He was transferred from SHU to CNYPC in 1999, diagnosed Delusional Disorder, and discharged back to SHU. He has been diagnosed Schizophrenic, in a Treatment Plan Review on 1/10/03, there is Dx Paranoid Schizophrenia and he receives outpatient care in GP at Great Meadows. He is prescribed anti-psychotic and mood stabilizing medications.

Example of:

SMI (Schizophrenia) in GP with OMH outpatient treatment

Spent much time in SHU

Condition worse in SHU

Tickets driven by voices, SMI, often when not taking medications

B.B.H. (Interviewed while housed in C Unit of General Population).

B.B.H. has been in prison since 1991 (including jail?). He was referred to OMH because he believes his food is being poisoned by the DOC, which he is certain of because of the shortness of breath, pain and altered states of consciousness he experiences. "They have something that puts you to sleep, and when you wake up you don't know what time it is.... They do this to people they think might be a leader of the future." He thinks the DOC would rather view a prisoner as mentally ill than deal with this problem. He has spent 11 months in SHU for two different tickets. He currently has a job as tier-tender. On his very thin clinical chart it is noted that he believes his food is poisoned. There is no diagnosis, no meds prescribed, and he fails appointments with mental health staff. There is a "Screening/Admission Note" for 1/7/93, indicating a suicidal gesture, he did not want to talk, no treatment and no follow-up. This man does suffer from a serious mental illness, likely Paranoid Delusional Disorder but must R/O Schizophrenia – but he does not receive mental health treatment and there is no diagnosis in his chart.

Example of:

SMI (Delusional Disorder vs. Schizophrenia) in GP

Has done time in SHU

Assessment and Treatment inadequate

He does not cause trouble

D.M. (Interviewed while housed in SHU).

D.M. burned himself in response to command hallucinations telling him to do so; this happened while he was not in treatment. He is prescribed Zyprexa, but his psychiatric medications have been given irregularly because he sometimes is non-compliant. He was admitted to observation on 1/28/03. He has many tickets for self-harm and destruction of property – he reports they are all on account of command hallucinations. He had been admitted to Bellevue Hospital psychiatric ward prior to incarceration. He has been in SHU or Keeplock since October, 2002. His clinical chart reveals that in 2001 he was admitted from Elmira to CNYPC (4/6/01 – 5/4/01) and discharged to Clinton. His diagnoses include Adjustment Disorder and Impulse Control Disorder and mild Mental Retardation, but notes reflect a history of psychiatric problems prior to incarceration with prescription of Ritalin for 1 1/2 years and Thorazine circa 1995. A 4/11/01 Inpatient Core Evaluation at CNYPC resulted from self-destructive acts and threats, he was diagnosed Adjustment Disorder and prescribed Sinequan 50 mg./day.

In Feb., 2002, he is prescribed Zyprexa 10 mg. and Paxil 20 mg./day. He is rejected for ICP in May, 2002, for lack of motivation. A 6/9/02 note reflects depression and suicide intent by hanging. Many other admissions to observation for self-destructive behavior are noted. 4/25/03 Rx of Zyprexa 10 mg. b.i.d. plus Paxil 20 mg./day. Mental status is consistent with psychosis in partial remission, and there is some question of a low intelligence. This man seems quite disturbed, has a history of serious mental illness, and is repeatedly cycled from SHU to observation and prescribed anti-psychotic and antidepressant medications, yet OMH views his problems as behavioral rather than linked with serious mental illness. It is quite clear that his behavior problems are exacerbated by SHU confinement; he needs to be transferred to a mental health setting such as CNYPC or IPC, thoroughly assessed, and given a trial of therapeutic rather than punitive confinement to see if his psychiatric problems and behavioral problems can be diminished.

Example of:

SMI (psychosis, poorly assessed) in SHU

Cycle from SHU to observation and back to SHU

Under-diagnosed, un-diagnosed at CNYPC

Remains on anti-psychotic medications

Needs more thorough assessment and treatment

T.T.

This 34 year old Latino man has been in prison for eight years, mostly in Keeplock and SHU. He feels he is set up repeatedly for tickets. He believes he gets tickets for refusing to cooperate with mental health treatment. He was in a double-celled SHU and did poorly. When he is in SHU he cannot control his anger, and he tries very hard to stay out of trouble but often fails. He suffers from hyperthyroidism, he thinks because of his food being poisoned. He exhibits a delusional system that involves the officers moving him out of a double-cell Upstate situation and giving him a mental illness diagnosis. He says he was beaten while being transported to Great Meadow on 3/17/03. The psychiatrist at Great Meadows, Dr. Faruki, wants him to take fairly large doses of the medications. He has been assaulted by cell-mates, for example at Upstate. He says he is diagnosed Paranoid Schizophrenia, and his mental status examination is consistent with that diagnosis. He shares delusions about being tortured with heat to the extent his body is burned. He exhibits thought disorder and first rank symptoms consistent with Schizophrenia. He denies he suffers from a mental illness, and gives that as the reason he is not admitted to ICP. He is behind a shield now, but cannot fully explain how that happens. He also worries that the radiation he is receiving will cause burns on his penis. In his clinical chart, he is given a diagnosis of R/O Psychotic Disorder by history on 8/18/03, and he is MH Level 2. On 3/17/03 & 8/18/03 he has a diagnosis of Psychotic Disorder due to gen'l medical condition and on 4/17/01 there is a diagnosis of Bereavement. He is sent to SHU in March, 2002. His MH Level in Upstate SHU beginning in December, 2002, is six each month until it is changed to 3 on 3/17/03 (and he is involved in a fight on this date), to 2 on 3/21/03. He was admitted to OMH

caseload on 3/17/03 and discharged on 7/2/03. A Core Evaluation on 5/29/03 notes "Has verbalized in letters and verbally that he has been monitored through a virtual reality system which emits low grade radiation damaging his body." Further, "poor adjustment to the prison system. Is mistrustful and suspicious of the correctional system. May benefit from medication therapy but he refuses to accept that his delusions are not real. Need help to accept they are not real." Hyperthyroidism is noted. Delusions are again noted by nursing on 10/1/03, and he is determined to be "functional in general population." Several notes reflect his refusing mental health treatment in mid-2003. SHU mental health evaluation of 8/18/03 notes delusions. He is seen cell-side in SHU through Sept, 2003, and refuses treatment. On 10/1/03 he is in observation for refusing his thyroid medication. He is angry and uncooperative, and delusions are noted. In summary, this man is clearly suffering from delusions, is diagnosed psychotic by OMH, is uncooperative with treatment, and is left in SHU, where he decompensates and goes to observation at least twice and back to SHU, and then goes to CNYPC.

Example of:

SMI (Paranoid Delusional Disorder or Schizophrenia) in SHU

Under-diagnosed while narrative notes document delusions

Screening in SHU misses severity of illness

Cycles from SHU to observation and back to SHU

Non-compliant with treatment, and discharged while delusional

U-M.

(Interviewed while housed in SHU).

U-M has been in prison since 1996, and has been in SHU for a long time. In SHU, he admits to sensing the walls closing in on him, cannot concentrate, gets angry and the anger becomes uncontrollable, leading to tickets that lengthen his time in SHU. He cannot relax and he cannot sleep in SHU, which makes his mental condition worse. He sleeps two hours at a time, and then he is up again and the lack of sleep makes his mental illness worse. He does not go to recreation because he is afraid of being "hassled" by guards or having his cell searched. He is very depressed and is hearing voices – symptoms that have been with him since 1999. In March, 2003, he was admitted to CNYPC after setting fire to his cell. He says he did it because he was feeling frustrated and unable to control the hatred that builds up in him when he is in SHU. He was sent back to the Box (SHU) from Marcy. He overdosed on Tylenol, among other things, but the Tylenol O.D. was immediately after he was released back to SHU from CNYPC. He says it cannot be that he manipulates to get out of Box, because he actually dislikes time at CNYPC more than SHU. On mental status exam he exhibits flat and depressed affect, psychomotor retardation, and reports very credible auditory hallucinations. He halted taking medications because he had been promised programs that were not forthcoming. He hears the voice of a girlfriend who died in 1994. He also hears almost continuous self-deprecating voices. He has been to the tenth grade, and there is a question of his being deported to South America when he is released. In his clinical chart, he is diagnosed Adjustment Disorder on 9/28/02, he is MH Level 4 on 9/11/02; 3 on 9/28/02; 2 on 10/11/02; and 1 on 5/14/03. On 5/16/03 he is admitted to CNYPC with the diagnosis

Major Depression, Recurrent, after setting fire to his cell and overdosing on Tylenol in SHU. He was prescribed Paxil, 20 – 30 mg. per day & Trazadone 50 mg. He was discharged back to SHU on 6/11/03. He has had various diagnoses, including Maj. Depr. Dis, Recurrent, ASPD, Adjustment Disorder and no diagnosis – but never malingering. He has taken a series of antidepressants, including Wellbutrin, Prozac and others, and he is monitored in SHU by OMH. In summary, this man is clearly suffering from a psychotic disorder that includes depression, that is inconsistently treated and only goes into partial remission. His diagnosis does not include psychosis, but a 5/16/03 Screening/Admission Note & Psych Eval after he set fire to cell reports: “thought processes 10% coherent, 90% illogical, disorganized, influenced by violent idea of self-destructive behavior.... He has started to hear voices in the prison, but relates them to his belief in Voodoo.” His GAF was 30. He has at least two CNYPC admissions and was sent back to SHU each time, the last in April, 2004, and his diagnosis remains Maj Depr Disorder, Recurrent – in spite of notes reflecting clear psychosis during episodes of self-destructive behavior. This man is intermittently very disturbed with SMI and should not be in SHU.

Example of:

SMI (Depression with Psychosis) in SHU

Under-diagnosed or un-diagnosed

Cycles from SHU to Observation, CNYPC and back to SHU

Treatment Inadequate

Narrative notes reflect greater psychopathology

Q.S.

(Interviewed while housed in SHU).

Q.S. has been in SHU for four years and will only be released from SHU in 2009. He has been in prison since 1998 on his third bit. He complains about being constantly surveilled because he is a “special case,” and indeed, during our interview, a C.O. was glaring at him through the window of the door. He says he is being forced to “smell stuff,” and “my life is being publicized to the people of New York, I even heard my name on the radio.” He says being in SHU makes him nervous and he talks to himself. He has a shield over his cell door. He claims SHU attacks one’s sanity: there is no privacy, and because he cannot read and because he cannot concentrate in SHU, there is nothing to do. He believes he is being singled out, watched, and set up by staff. He believes the officers mess with his food. On mental status, he is very intense and angry, exhibits pressured speech with obvious ideas of reference and First Rank Symptoms, and he has an obvious neurological problem involving involuntary movements. When I ask him about the involuntary movements he says they began in SHU. He has been on the anti-psychotic medication Seroquel, but he is not aware of ever being prescribed phenothiazines (which can cause involuntary movements). He has not been admitted to CNYPC. He was in observation at Auburn for one day. He does not see OMH except when they make rounds at cell-front. He would like to go to STP. He does not go to recreation. Steve Martin was told by another prisoner that this prisoner is the most disturbed prisoner in the SHU, and has “gassed” other prisoners. His clinical chart

contains diagnoses of Delusional Disorder and Psychotic Disorder NOS, yet he is repeatedly Mental Health Level 6 except when in acute crisis (7/01 and 7/02), when he becomes Level 1 or 2. He is admitted to observation on several occasions, and then back to SHU. He is prescribed Seroquel, but is often non-complying with meds. He was in STP in July, 2001, at Attica. This man is clearly psychotic, probably Delusional Disorder but must rule out Schizophrenia. He also has a neurological problem that warrants study. He has a long SHU term, has been diagnosed psychotic and delusions are repeatedly noted by OMH staff, and cycles to observation. In other words, he is known by OMH to be psychotic, is warehoused in SHU with intermittent medications and little but cell-front intervention. He has been in ICP. He should not be in SHU because his condition deteriorates in isolated confinement; he needs to be in a residential treatment setting such as ICP.

Example of:

SMI (Delusional Disorder or Schizophrenia) in SHU

Cycles from SHU to observation and back to SHU

Under-diagnosed

Narrative notes re delusions, not reflected in diagnosis

Very inadequate treatment

Went to STP, return to SHU

Y. Y.

(Interviewed while housed in SHU).

Y. Y. has been in prison for seven years on this, his second bit. He has been in SHU for five years. He has been hearing voices for quite some time, and attributes his rule breaking to command hallucinations. On Aug. 21, 2002, he cut his wrists because the voices commanded him to do it. He has attempted suicide by cutting, has a history of not eating, and has lost weight (down from 275 to 190). He is currently on "loaf." One cutting incident occurred after an officer gave him a razor. He has been to observation many times, the last time was for cutting an artery. He says that being in the Box makes him think of killing himself all the time. He shows me multiple scars on his forearms. He has asked to be in ICP but is told he needs to be in SHU because of his large size. He was admitted to CNYPC in 1998 and diagnosed psychotic. He is prescribed Seroquel, but states it does not really help with the voices, which he still hears. He admits to feeling paranoid, for example fearing they are recording our conversation and that someone will do something bad to him. He gets depressed and hears self-deprecating voices. All of his psychiatric symptoms get worse in the Box. He sees the psychiatrist once a month for five minutes. He has been to observation many times. He has set fires a few times, each time in response to command hallucinations. He gets black outs, and has had an MRI. On mental status, he is earnest, depressed affect, and displays some memory lapses. This man is clearly psychotic and depressed, and his serious mental illness is made worse by SHU confinement. Clearly his tickets result from behaviors commanded by voices.

His clinical chart fills a file carton. He has at least four admissions to CNYPC 5/14/98 – 6/10/98; 3/9/99 – 6/16/99; 12/28/00 – 3/13/01; 4/25/02 – 5/31/02. At one point he was discharged from CNYPC after being admitted for slashing an artery in a suicide attempt, and it was recommended that he not be returned to SHU – yet he was returned to SHU. His diagnosis is Psychotic Disorder NOS on 1/21/98 & 6/16/99; Major Depressive Disorder on 6/16/99 & 3/20/01 (the latter with psychotic features). An update of his mh record on 3/17/99 states that he has a long SHU term and “Essentially we might as well say that he is going to be in SHU the remainder of this incarceration.” He is repeatedly suicidal, hears voices, is assaultive, sexually indecent and otherwise disruptive. When he was admitted to the mental health unit at Five Points on 12/27/00 “He was actively psychotic, violent, and suicidal. He was banging his head against the wall but received no injuries. He wanted to die and stated if someone tried to stop him he would hurt them. He did hit a corrections officer in the head when the officer tried to stop him.” There are conflicting notes about psychiatric history prior to incarceration, some saying he was hospitalized and on medications. IQ tests at age 14 and on admission to DOCS register an IQ around 71. Records show he has been prescribed Thorazine, Risperdal, Haldol, Sinequan, Seroquel, Paxil, Benadryl, Zoloft, Trazadone, Zyprexa, Klonopin, Cogentin (per update 4/29/02). A Behavior Management Plan, SPL 1, was ordered during admission to CNYPC in May, 2002, when he was self-destructive with razors and had a deep cut on his arm. In May, 2002, after psychological testing at CNYPC (6/5/02 by Dr. Wilson), his diagnosis was changed to “No Diagnosis” on Axis I and ASPD on Axis II, and a Behavior Management Plan was designed, including the directive that he was not to be seen by his therapist for at least 24 hours after self-injurious behavior so he won’t injure himself to gain attention. He is returned to SHU at Great Meadows. A Special Mental Health Status report by psychiatrist, Dr. Byung Kim, on 8/31/02 notes psychiatric history pre-dating incarceration, auditory hallucinations, diagnosis was Psychotic Disorder NOS with prescription of Seroquel 400 mg./day. On 1/13/03 he is admitted to observation because of “psychotic symptoms, talking to himself, responding to internal stimuli.” He scratched his arm and required a cell extraction. On 5/23/03 his Seroquel was raised to 300 mg. per day. On 9/30/03, his diagnosis was “No Diagnosis” on Axis I and ASPD on Axis II, and Behavior Mgmnt Plan was still being followed in SHU – and he was once more transferred to observation. Through 2/04, he continues to be seen cell-front in SHU, assigned “no diagnoses,” continues not to improve with treatment while in SHU on anti-psychotic medications, intermittently smears feces, sets cell on fire, and attempts to kill himself, by acts that are now branded “pseudo-suicidal.” Even though he is given “no diagnosis,” progress notes continue to evidence psychosis with hallucinations, depression and suicidal intent and actions. He continues to cycle to observation and back to SHU, even though he is no longer admitted to CNYPC. For example, a note of 5/8/02 at CNYPC states: “Debriefed with [redacted] after incident last night in which he assaulted staff and required restraint [redacted] said he was hearing the voice of his deceased grandmother (whom he never has seen). She was telling him to do things.... He also said he sees blood dripping from the faces of his two dorm mates at night and it scares him....” He continues to be given tickets for incidents that occur while psychotic symptoms including command hallucinations are reported in the progress notes.

Example of:

SMI (Psychosis, probably Schizophrenia) in SHU

Deteriorates in SHU

Cycles from SHU to Observation & CNYPC

Tickets related to command hallucinations

No known consideration of mental illness in disciplinary process

Un-diagnosed at CNYPC Continued on anti-psychotic medications, continued psychotic symptoms

Continued on strong doses anti-psychotic medications

J.O

J.O has been in prison for nine years and in SHU for 43 months. He believes he is considered a security threat. He does not get tickets – his last was in 1999. He says they write reviews of SHU prisoners, but they don't interview you. He says that officers taunt prisoners with mental illness and drive them off the deep end; some do it for amusement. He spends his time reading and doing legal cases. He denies emotional problems. His chart corroborates what he says. There are very superficial periodic mental health screens, obviously done at cell-front. He has no report of mental health problems in his chart, and he is Mental Health Level 6.

Example of:

Long-term SHU, no known SMI

K.E.

K.E. has been in prison for 23 years and will be released in 2007. He has been in SHU for 14 years because of a riot that occurred in 1991. He is comfortable in SHU because he says he was being picked on and beaten up in GP. He sees Ms. Kim twice a month in the mental health unit office. He is prescribed Zyprexa, 15 mg./day, and it cuts down on the voices he hears. He has been admitted to CNYPC four times, and has been to observation a dozen times for suicide attempts driven by command hallucinations. He has had no tickets for two years. He goes to recreation and exercises. He says they have begun giving tickets to prisoners who refuse to go to see the mental health staff, and if you refuse your medications three times they discontinue the treatment. He spent six months at CNYPC, where "they do not lock you up," and liked it there. "Dr. Faruki refuses to send you to CNYPC when you are disturbed; instead he has you locked up in an observation cell in the middle of winter with the window open, telling you he's punishing you so you'll go back to your cell." He spends his day reading and writing, exercising, and laying in his bunk. On mental status exam he has flat affect, he is earnest and coherent. His history is credible and he exhibits no current delusions. His clinical chart is consistent with his history. He had psychiatric treatment as a child and cut himself in a suicide attempt in 1975. He is considered a leader of the 1991 riot, and he is considered assaultive and self-harming. In 1991 he was diagnosed Adjustment Disorder, but prescribed Haldol 5 mg. b.i.d. Over the intervening years he has had many

long admissions to observation for suicide risk, has been prescribed Thorazine 100 mg. to 300 mg. per day as well as various antidepressants, and has been considered assaultive. His diagnosis has varied, from Psychosis NOS to Adjustment Disorder with disturbance of conduct and ASPD. In 1998, he was diagnosed Schizophrenia, Paranoid Type. His fifth admission to CNYPC occurred in 7/98, for attempted hanging, diagnosis Paranoid Schizophrenia and prescribed anti-psychotic medications. I found no mention of STP in the chart I reviewed. This man suffers from a serious and persistent mental illness and is taking anti-psychotic medications during long-term SHU confinement. He needs to be in a treatment setting such as ICP.

Example of:

SMI (Psychosis, Schizophrenia) in SHU

Cycles from SHU to observation, CNYPC

Tickets related to command hallucinations

Un-diagnosed, but continue anti-psychotic medications

O. A.

. (Interviewed while housed in ICP).

O. A. has been in prison for 19 years. He has been in ICP for a year. He eats in GP mess hall, or, if he feels paranoid, he is fed in his cell. He reports that mental health staff do not help if you get a ticket, and you will probably be sent to SHU. He has been admitted to CNYPC 18 or 19 times, when he has heard voices and felt paranoid and depressed. He thinks SHU is like observation; both are awful. He has been hearing voices since the age of 13, and had pre-incarceration admissions to psychiatric hospitals. He has been in observation for up to a month, and has only talked to mental health at cell-front when there. This man obviously suffers from a severe and persistent mental illness, most likely Schizophrenia, and he is taking medications while being confined in ICP. A review of his chart reveals 20 admissions to CNYPC, a murder conviction at age 16, a history of closed head injury with possible organic brain syndrome, prescription of Depacote and Prolixin, a stay in ICP, and a note that he is not cooperative with mental health treatment.

Example of:

SMI (Schizophrenia) in ICP

Many trips to observation & CNYPC

Long stints in observation, poor treatment

Cell-front interviews

I. X.

. (Interviewed while housed in ICP).

I. X. has been in prison since 1992, and has been in ICP for six months. Prior to that he was in GP. He is prescribed Zyprexa and Paxil. He still hears voices and gets depressed, but he is better when he takes the medications. He has been admitted to CNYPC seven times, sometimes when he was self-destructive, sometimes when he was too aggressive. He does very poorly in SHU, where he has been twice, for up to six

months (at Attica). From the Attica SHU he was transferred twice to CNYPC and back to SHU, and also cycled to and from observation. He tends to go to CNYPC when he becomes paranoid and stops eating. Once he was in observation for 19 days, he explains "they don't like sending guys to Marcy so they keep us in observation." He says if you get a ticket in ICP, they kick you out. "In GP, guys make fun of you." This man obviously suffers from severe and persistent mental illness, most likely Schizophrenia, and is doing OK on medications at ICP. Previously he cycled between Attica SHU and CNYPC and observation.

Example of:

SMI (Schizophrenia) in ICP

Had been in SHU, cycled from SHU to observation & CNYPC and back to SHU

J.U. . (Interviewed while housed in Keeplock General Population).

J.U. has been in prison for 12 years, and is currently on Keeplock status in GP. He has been to CNYPC many times, mostly for depression and being suicidal. He has tried to starve himself and has lost a lot of weight in the past. In 2001 he was in observation at Clinton for three months, and Dr. Melendez said she would keep him there forever if he didn't eat. He has had psychiatric problems since the age of seven. He is Jamaican and faces deportation when he is released. This man seems credibly severely depressed and is prone to suicide, but it seems he is held in observation for very long periods, even while losing a lot of weight. Review of his chart reveals four CNYPC admissions, often for suicide, with diagnosis of Adjustment Disorder with Mixed or Anxious or Depressed Moods, Depression, Anxiety Disorder and Malingering. He also is alleged to make lewd gestures or expose himself on occasion to female staff. In 9/98 he had been to CNYPC and was in a depression group. On 10/26/99 he was noted to be depressed with rigid & constricted thought patterns and chronic suicide ideation. Medications as of 10/26/99 included Zoloft 100 mg., Neurontin 900 mg. b.i.d., and Vistaril 100 mg. He continued to become seriously suicidal (he was once found hanging "secretively" and had to be cut down), is given a diagnosis of Adjustment Disorder and antidepressant medications. At other times he is diagnosed Depression NOS and prescribed stronger medications. For example, in June, 2000, he was taking Depacote 1,500 mg. per day and Zoloft 200 mg. per day. Between admissions to CNYPC he is usually MH Level 6, and he spends a lot of time in SHU because of misbehavior. In Jan., 2001, he was put on a behavioral plan. In June, 2001, he was re-admitted to CNYPC with a diagnosis Depressive Disorder NOS, after again threatening suicide. This man is clearly chronically depressed and suicidal, and has been diagnosed and treated for that condition, including multiple admissions to observation and CNYPC and the prescription of strong psych medications. He is also disruptive and manipulative. Too often staff ignore his bona fide depression because of his manipulateness, and his emotional symptoms are thus relatively downplayed. In other words, he is repeatedly given a diagnosis of malingering/no diagnosis, but then becomes disturbed and self-destructive and

cycles into treatment. Clearly he suffers from Major Depressive Disorder, Recurrent, and is un-diagnosed during remissions.

Example of:

SMI in SHU (currently Keeplock in GP)

Long stays in observation

Severe Major Depressive Disorder, recurrent

Under-diagnosed as Adjustment Disorder

Medicated as if severe mood disorder

Un-diagnosed during relative remissions, and mental health level upgraded

A. H.

(Interviewed while housed in SHU).

A. H. refuses mental health treatment and stays in his SHU cell all the time. He has spent his entire term in the Box. He says "I am feeling out of control right now." He thinks he is being treated better than usual right now because of our visit. He has not been to ICP. His psychiatric problems are made much worse by confinement in SHU. He feels the cell walls close in on him. He is unable to focus enough to read, and he cannot concentrate. This man is frankly paranoid, his anger is barely under control; he is self-destructive, and all of these problems are aggravated by his confinement in SHU. Steve Martin saw him and became concerned about his risk of suicide. He is too paranoid to seek mental health treatment, but he does have self-destructive inclinations. SHU is obviously aggravating his paranoia and self-destructive urges.

Example of:

SMI (Paranoia, Depression) in SHU

Refuses to seek mental health treatment

Deterioration in SHU

Caught in Bind: Does not trust OMH, severely disturbed, not treated

Wende Correctional Institution – 9/22/03 and 9/25/03

A. V.

(Interviewed while housed in ICP).

A. V. has been in prison for ten years. He suffers from mental illness and low intellectual function. He was in the SNU, was transferred to SHU for ten months, then was transferred (with the help of PLS attorneys & a time cut) to ICP in September, 2002, and remains in ICP – where he says he does well. He believes the charges that led to his SHU term were fabricated by a C.O. who did not like him. He did very poorly in school and is not literate. He had head trauma with brain damage at age nine or ten. He is prescribed Vistaril and Zoloft. He has spent a lot of time in SHU. He did not do well in SHU, and experienced hallucinations – he saw faces of ladies, no voices – he was very anxious and afraid of self-harm, suffered palpitations and headaches, he was paranoid that people were playing tricks on him, when he is behind Lexsan (he was from 1995 through 1997) he cannot breathe and gets even more anxious. He believes the guards messed with his food while he was in SHU, talks to himself and stays up all night. He

went to observation several times from SHU, but never to CNYPC. He set fire to his cell on more than one occasion – he reports that he was feeling desperate because the food was so bad, and he could not control his impulse to set his shirt on fire. He bangs his head as a desperate way to get help for his other emotional problems. On mental status examination, this man is oriented but grossly deficient in cognitive and memory functions. He cannot do serial 7's, and with serial 3's he cannot understand the notion of "take away" or subtract. He has a misshaped head and many scars. He seems depressed, vulnerable, and has low IQ. This man is very depressed, suffers cognitive impairment from DD or head injury or both, and is very vulnerable in prison. He has severe psychiatric sequelae when he is housed in SHU.

Example of:

SMI (Depression, R/O psychosis) and Mental Retardation in SHU

Condition deteriorates in SHU

Transfer to ICP, finally, and does better

M-H

. (Interviewed while housed in observation).

M-H was transferred to observation from an S-200 unit at Collins Correctional Institution a few days ago, where he is on Keeplock status. He has been in prison five years, with three priors. He is to parole in January. He has never been to CNYPC, but this is his third admission to observation. He tried to hang himself with a sheet. He had been depressed and irritable, and then they made him share his cell, which frightened him that he might jump on his cellie. He says there are cell-fights daily in the S-200. He says he was given Keeplock because a shank was found in his light, but it was there before he entered the cell. He says that in observation there are daily rounds at cell-front and meetings with the team in a separate room. He feels staff do not pay attention to the needs of prisoners in observation, and he had to scream for 15 minutes to get water. He has been taking Seroquel for five months on account of the voices. On mental status examination he is wearing a gown. He exhibits moderately depressed affect and a credible history of command hallucinations telling him to cut himself. He hears other voices, telling him he is bad, he does not belong, etc. He does not think OMH intervenes when prisoners on the caseload get tickets. He does not know if he will receive a ticket for hanging up. His clinical chart contains a diagnosis of Adjustment Disorder with Depressed Mood on 3/21/03. Mental Health staff seem to feel he manipulates for fear of going to GP. But he is prescribed Seroquel 200 mg. per day as of 12/15/03, and hallucinations are noted periodically in his chart in spite of continuing diagnosis of Adjustment Disorder. On 1/30/03 he was returned to the Orleans S-200 after 2 days in the RCTP. On 3/14/03 he was returned to RCTP. This man with depression and psychosis, Rx Seroquel, is in observation because living with a cellmate in S-200 is unbearable for him, and his symptoms include command hallucinations and he is prescribed an atypical anti-psychotic. A chart note reflects Dr. Langbart discontinuing Seroquel in Feb., 2004. He cycles from SHU to observation and then back to SHU, and the MH staff repeatedly underdiagnose him.

Example of:

SMI (Depression with Psychosis) in SHU/S-200

Problems with cellmate

Un-diagnosed or under-diagnosed

Still, strong anti-psychotic and antidepressant medications prescribed

V. D.

. (Interviewed while housed in RCTP dorm).

V. D. is in the RCTP dorm, has never been in SHU, was in the RMU in Cocksackie and before that in GP. He came off a 30 day hunger strike at Great Meadows which he did because "they poisoned the food." He is in RCTP because he swallowed a spring and some paper clips. He says he would kill himself if they send him back to GP at Wende. He claims the officers are all family at Wende, and they are hard on non-blacks. He had been in psychiatric hospitals prior to incarceration, including Dorothea Dix during trial to determine competency and mental state. He has been prescribed Lithium and Thorazine in the past, but is currently on no psychiatric medications. He hears voices commanding him to take his own life. He has spent up to a month in observation while on a hunger strike. On mental status he exhibits flat affect, concreteness and a picture consistent with chronic Schizophrenia or Borderline (severe) Character Disorder with Psychosis and Depression. He was admitted to Dorothea Dix Hospital in Raleigh, North Carolina, in 1989 for depression, and was prescribed Thorazine. A 3/12/04 discharge summary from Erie County Medical Center (admission to medical ward) notes malnutrition from a hunger strike while at Wende. He remained there for three days and was transferred back to Wende with a nasogastric tube in place on 3/12/04. It is noted that this hunger strike commenced January 4, 2004. A DOCS/OMH treatment Progress Note for 3/24/03 contains a diagnosis of Antisocial Personality Disorder, no medications given, and a treatment plan opines that he is using mental health contacts as a manipulation. As a management plan, he will be seen only once per week on Tuesdays, there will be weekly staff meetings about him, and the goal will be for him to maintain his weight and hydration. A 1/15/04 discharge summary from Erie County Medical Center notes admission following overdose/ suicide attempt while on a hunger strike. History includes several prior suicide attempts, by ingestion of razors, toxic substances, etc. He reported to staff there that he had been raped by staff and beaten at Wende, and was terrified of going back there. History given to physician included prescription of Lithium and Thorazine as recently as 1999 in DOCS, but he has not taken them since "because they don't give them to me." Psychiatric signs included "On psychiatric exam, while talking to the patient, would reveal that he is depressed, he does have suicidal ideations, anhedonia, insomnia, appetite derangements and is tearful." Discharge Diagnosis: "1. Depression, with suicidal attempts, 2. Seizure Disorder, 3. Drug abuse, 4. Attempted Overdose." At the same time, there is a note that says the psychiatric consultant felt that there was no psychiatric problem, but the patient required one-on-one observation for suicidality(??) There was no follow-up to the complaint of rape, and the only ethics committee discussion that occurred seems to have involved his competence – it was decided he was competent. A June 26, 2002 RMU Nurse Practitioner Monthly Note at Cocksackie RMU reflects that he has claimed to have been

raped by two COs at Clinton, that he is diagnosed with seizure disorder as well as a history of depression, suicide attempts and malingering. On 6/30/04 he was discharged from RMU and moved to "the Box" because he refused to go to A Block where he had had trouble with officers. From the Box he was sent to the MHU for swallowing a fork, and then back to the Box. He also has been on Keeplock for a substantial period of time. This man suffers from chronic and persistent mental illness, possibly Schizophrenia but at least severe Borderline Character Disorder and Depression with recurrent psychotic decompensations, and is terrified of GP at certain institutions. He is repeatedly diagnosed ASPD, on little evidence and with little formulation on the chart except he is manipulative. He definitely suffers from a more severe mental illness. He probably does do hunger strikes to gain a transfer when he is terrified, but he is also very depressed and starves himself nearly to the point of death. He is repeatedly sent to observation, never to CNYPC inpatient. He needs a somewhat protected, and more therapeutic setting; ICP would be a good placement.

Example of:

SMI (Depression, must rule out psychosis) in GP

Not in SHU, Medium Security

Cycles from GP to observation or CNYPC

Considered manipulative only by OMH

V. Q.

(Interviewed while housed in ICP on Keeplock).

V. Q. has been in prison for seven years. He is in ICP on Keeplock because of a dispute with another prisoner. He had been in ICP at Sing Sing. He describes his tendency to give things away, and then get mad at another prisoner for not reciprocating. He has been admitted to CNYPC several times. He was in SHU for two years around 1996, and vowed never to return. He is prescribed Zoloft, but in the past took Lithium and Haldol. He was diverted from corrections to Mid-Hudson in 1995, where he remained for a year. On mental status, this man is clearly disturbed and bizarre, he exhibits flat affect, very idiosyncratic language, neologisms, some incoherence, tangential thinking and loose associations. He is likely suffering from chronic Schizophrenia or a related disorder, and is managing on medications in ICP. His clinical chart is consistent with his history. He is diagnosed Schizoaffective Disorder with substance abuse and ASPD. He was admitted to CNYPC on 1/28/03, with that diagnosis and meds Geodon 80 mg. b.i.d., Tegretol 400 mg. b.i.d., Neurontin 800 mg. b.i.d. and Vistaril 150 mg./day. He evidently is admitted to CNYPC when he is manic, expresses flight of ideas, and becomes belligerent. He manages OK in ICP when he takes his medications. He has been in restraints when out of control, and has been considered for medication over objection.

Example of:

**SMI (Schizoaffective) in ICP, has spent two years in SHU
Actively psychotic now**

F.F.S. (Interviewed while housed in SHU).

F.F.S. seen while in Wende SHU by Terry Kupers and Steve Martin on 9/22/03, is not on the OMH caseload. He has been in SHU for a month and a half. He has been in other SHUs. He was sent to SHU from GP at Wende because of an alleged fight. He reports they have been "moving guys with mental illness out of SHU in preparation for our tour." He says most guys with mental illness miss recreation because you have to stand up fully dressed and yell out when the officer comes by, and they cannot do that. Similarly, prisoners with SMI miss chow, showers, etc. He says the COs treat guys with mental illness the same as they treat the others – and that's the problem, they should treat them differently. Being in SHU makes him angry. His thick clinical chart contains no mental health diagnosis; there is a note in which he requests to see psych to get sleeping meds for insomnia--no medications are noted, and there seems to be no psychiatric treatment.

Example of:

Untreated prisoner in SHU

Need for mental health services not pursued

Describes victimization of prisoners with SMI

X.N. (Interviewed while housed in SHU).

X.N. has been in prison for 11 years and is seen in SHU where he has been for the past five months, and for much of his time in prison. He is depressed and sleeps excessively. He has attempted suicide by swallowing a battery. He has been to observation for depression and risk of self-harm. He finds the time in observation a welcome break to the constant noise of SHU. He is prescribed Prozac and Vistaril and is on the honor block side of the SHU. He has not seen the psychiatrist since entering SHU. He has asthma and is very nervous that the poor medical response he sees when prisoners have heart attacks means that he will not get the care he needs. He says that mental health staff only recently began making rounds in the SHU – he thinks a suicide at Greenhaven was the reason they started doing rounds. In SHU, his depression gets much worse, he gets very lonely, there are no activities, he feels the walls are closing in on him, he gets paranoid he'll be charged with something he did not do. He says that prisoners with SMI in SHU make a lot of noise and keep the others up all night. He thinks he has problems sleeping because of all the noise, especially from prisoners who are "behind glass" (Lexsan). He reports that most SHU prisoners miss recreation most of the time because they go by unannounced and you have to be standing, dressed, etc. Prisoners also miss meals and showers for the same reason, especially those with mental illness. On his side of the SHU, guys help each other – on the other, non-honor block side, they aren't as helpful, and that's where a lot of guys with mental illness are placed. His chart

corroborates his history, he is diagnosed Adjustment Disorder w Depressed Mood, he has been to observation several times for self-harm, not to CNYPC.

Example of:

**Depression in SHU, goes to observation for self-harm threat
Afraid because medical condition (Asthma) not treated
Receiving little or no mental health treatment**

W. M.

(Interviewed while housed in SHU).

W. M. cuffed in front with a waist chain, appears angry and delusional, even as he denies any mental health problems. He has been in SHU since March, 1999. He was in Southport from Jan., 1992, through March, 1999. When asked why he is in SHU for such a long time, he says "they have questions about my behavior." He says he stays to himself, does not talk to prisoners in neighboring cells, rarely goes to recreation, takes showers "now and then," and has eight or nine tickets, mostly for contraband such as a CD. He theorizes that Sen. McCain's brother has been plotting to keep him in SHU this long, and says of course he's angry. He does not take any psych. meds and says he does not need any. He seems delusional and in denial. His thin clinical chart contains diagnoses of Psychotic Disorder NOS on 2/26/99, and Schizophrenia in partial remission on 5/5/03. On 6/9/03 his diagnosis was changed to Schizoaffective Disorder. There are notes reflecting disorganized behavior and thought disorder throughout OMH notes from 2001. He was admitted to CNYPC in 1988 with diagnosis of psychosis, not since. He was transferred to ICP at Wende 6/5/03. So this man was known to OMH as suffering from serious mental illness, i.e. psychosis, and yet he was left to spend years in SHU until his condition became so obviously deteriorated that he was transferred to ICP only after I saw him in SHU.

Example of:

**SMI in SHU for years
Moved to ICP just before my tour
Not compliant with treatment
Inadequately assessed, but known by OMH to be Schizoaffective**

S. C

. (Interviewed while housed in SHU).

S. C has been in prison for seven years and he has been in SHU for 14 months. He has a ticket for fighting with another prisoner. He has received five tickets while in SHU for reasons he claims are minor, such as complaining about denial of legal visits. In GP he rarely received tickets, maybe a tier 1 or 2. He explains the fact he receives more frequent tickets in SHU as a consequence of "they keep you in a box here." He says they refuse to give him a form to appeal tickets. He was admitted to CNYPC once, but was told he was too violent to remain in Mental Health treatment. He was at CNYPC once, three months ago, and was prescribed Benadryl and Seroquel (twice per day). Then they stopped the medications while he was in observation at Clinton. He was

in observation for two weeks in July, 2002, after they "gassed his cell," they say because he refused to cuff up. They did an extraction without giving him a chance to agree to exit, and mental health was not contacted. He was given a ticket for that incident, but it was later thrown out. He was also beat up while in Keeplock because "I wanted to talk." He was naked with no gown and no clothes for two weeks in observation, and nobody came to talk to him. He threatened to "hang up." He was also in observation at Clinton one other time. He hears voices and becomes very depressed. The medications they gave him in observation helped. The voices and depression are much worse in SHU, and his suicidal ideation mounts. He sees Dr. Kravitz on rounds in SHU, but he does not talk about much because "I don't like to put my business out in front of my cell." He experienced command hallucinations telling him to kill himself, and that was the reason he was admitted to CNYPC. He has been hearing voices since the age of 13, command hallucinations telling him to do bad things and hurt people. He abused drugs and alcohol prior to incarceration. He earned a GED in 2000. He reads, but not in SHU because he is unable to concentrate or focus. All of his symptoms are much worse in SHU. On mental status examination, he exhibits flat affect, and reports hallucinations and depressed affect. There are ideas of reference, he is disoriented as to date, he is articulate, but he cannot abstract and seems confused about what is going on. He definitely suffers from SMI, likely Major Depressive Disorder with Psychotic features. In his clinical chart, there are diagnoses Schizoaffective Disorder (Bipolar Type), Delusional Disorder, and ASPD. While at CNYPC (5/29/03 – 9/10/03), Psychological Assessment (6/23/03) was done by John Pelkey. Results include psychosis, probably Schizophrenia, and mixed personality problems including significant authority problems and ASPD. An ICP setting is recommended, but prognosis is guarded. He was actually returned to SHU, and by 5/11/04 he remained in SHU with the diagnosis Schizoaffective Disorder, medication, Zyprexa 15 mg. b.i.d., actively hallucinating and delusional. This man continues to be actively psychotic in SHU, and should be transferred to an appropriate treatment setting such as ICP.

Example of:
Active psychosis in SHU
Under-treated
Cell-front interviews

P.W.

(Interviewed while housed in SHU).

P.W. has been in prison for 12 years and SHU for 26 months. He was admitted to CNYPC last month, from observation after he tried to overdose and hang himself. He received a ticket for self-harm, which was dismissed. He has received six tickets in DOC, all for self-harm. He is serving 25-to-life for an escape attempt in 2002. He reports very depressed moods alternating with "highs," for which he is prescribed Depacote, and recently Risperdal. He is also prescribed Celexa. His emotional symptoms become worse in SHU because nobody talks to him. He claims a C.O. tells him that he's suicidal, and "Why don't you just do it?" He says the C.O.s treat prisoners with mental illness worse, in part because the C.O.s think the prisoners are faking. He

hears derogatory voices when he is depressed. Many of his suicide attempts are ordered by command hallucinations. He says it is very cold in observation, and they give you a mat and a gown. Team meetings with prisoners in observation last only a few minutes. He is unable to concentrate and read in SHU. He gets more paranoid in SHU, and feels the C.O.s also treat him in a mean fashion because of an assault on an officer that occurred during his escape attempt. He paces in his cell quite a lot, and talks to himself. He had a history of serious mental illness prior to incarceration. On mental status, he smiles and is coherent, he credibly reports wide mood swings and severe depression with command hallucinations. He is soft-spoken and has a sense of humor. He seems to suffer from a Bipolar Disorder, and is currently in mid-cycle.

In addition, to reviewing this prisoner's inpatient mental health records from CNYPC, and his entire outpatient mental health chart for the period of his incarceration from 1994 until the present, I have reviewed the following documents: the court decision in his case; Facility Reports regarding the July 29, 2001 incident; the transcript of the initial hearing; his disciplinary history; a 5/12/92 evaluation report by substance abuse counselor Christopher Taylor; a letter from the prisoner dated 2/14/99 to Auburn Memorial Hospital; and an Auburn Memorial Hospital report dated 2/4/99. He suffered an extremely abusive childhood, the loss of his mother at age nine, and placement in multiple foster homes, group homes and so forth. There were many traumas. He has a long criminal record, with previous prison terms. He also has a long record of polysubstance abuse with multiple attempts at rehabilitation. And he has a long history of serious mental illness.

A 5/12/92 assessment by chemical dependency counselor in the community, Christopher Taylor, notes "occasional depression, mood swings, and anger control problems." Mr. Taylor notes that he has experienced "auditory hallucinations" and "blackout spells," and has undergone psychotherapy and has been prescribed psychotropic medications. This prisoner's history of mental illness is also noted in a 10/5/95 NY DOCS outpatient mental health progress note. That note indicates that his mental illness includes "chronic depression with serious potential for suicide, physical and sexual abuse as child, has taken Mellaril and Elavil, on Prozac 20 mg./day, Atarax 75 mg./day, has a drug and alcohol history."

He has been seen by outpatient mental health providers within the NY DOCS almost continuously since the beginning of his current term in 1994. He has been prescribed antidepressants and anti-anxiety medications for most of that period, along with occasional anti-psychotic medications. Diagnoses while in the custody of the NY DOCS have included Depression (alternatively Dysthymic Disorder), anxiety disorder, polysubstance abuse, antisocial personality disorder, borderline personality disorder, Major Depression with Psychotic Features, and Adjustment Disorder. For long periods he was seen in outpatient psychotherapy monthly or every three weeks, for sessions lasting a minimum of 30 minutes. On several occasions he was admitted to the RTCP for suicide attempts or crises interventions. In early 1998 his psychotropic medications were discontinued for a short time. However, in March, 1998, there is this note by psychiatrist

Dr. Kathleen Nelson: "depressed mood, decreased sleep, crying spells, decreased energy and overwhelming sadness. Restart Prozac 20 mg., Vistaril 50 mg." A 4/29/98 progress note assigns the diagnosis of Major Depression, moderate, recurrent," and the dose of Prozac is doubled to 40 mg., while the dose of Vistaril is increased to 100 mg. In the ensuing months Atarax and Sinequan are prescribed in addition to the other medications.

On 2/4/99 this prisoner is transferred to the Auburn Memorial Hospital because of an overdose of his prescribed medications, presumably a suicide attempt. And on 2/5/99, he is admitted to the RCTP. At that time he is noted to be, "agitated and anxious." Once again on 4/30/99 "threats of self-harm" are noted, he is observed to be agitated with "ruminations of hopelessness and inadequacy and significant risk of self-harm." Inappropriate affect – smiling – is noted on several dates. On 6/9/99 he is re-admitted to the hospital after cutting his arm, and there is the first mention in his chart of manipulation, to wit: "Clearly this inmate is manipulating for his environment." He is moved into and out of the hospital and RCTP until 6/11/99, when he is transferred to honor housing on another cellblock. He continues to receive psychotherapy and to be prescribed Prozac 40 mg./day. Eventually, Prozac is increased even further, to 60 mg. per day. After attempting "to hang-up" at Wende Correctional Facility, (it was also noted that he was refusing to eat and was mute and catatonic), he was admitted as a psychiatric inpatient to CNYPC on August 10, 2001 with a diagnosis of "Major Depressive Disorder". He made a suicide attempt while in the hospital on 8/19/01.

This prisoner was involuntarily committed to CNYPC by the Supreme Court, County of Oneida, as a mentally ill inmate on 9/20/01, on the recommendation of two psychiatrists who found him mentally ill and suicidal. At the time he was admitted he was being prescribed Prozac 60 mg./day, Atarax 200 mg./day and Risperdal 2 mg./day. He was noted to have many symptoms of Posttraumatic Stress Disorder (PTSD), including flashbacks, insomnia, agitation and social isolation. While he was an inpatient at CNYPC, Psychologist John Wilson, Ph.D., administered a number of psychological assessment instruments, and concluded that this prisoner was functioning at a borderline level of personality development, that he suffered from some gender confusion and sexual identity difficulties, that he utilizes the primitive defense mechanisms of splitting, projection, projective identification and omnipotent control, and that he "will show faulty judgment and reality testing when angry or enraged. Dr. Wilson opined that he was dishonest, that he was malingering, and that treatment would be very difficult. Meanwhile, while he was in the psychiatric hospital, he was taking Risperdal 2 mg. twice per day as well as Seroquel 100 mg. or 200 mg. per day, plus Celexa 20 mg. per day and some minor tranquilizers. He was discharged from CNYPC on October 4, 2001, with the Diagnoses "Major Depressive Disorder, With Psychotic Features, Polysubstance Dependence, and Antisocial Personality Disorder with Borderline Traits." His discharge notes mention that the hallucinations and delusions he had been suffering, had diminished or were absent by the time of discharge. After discharge from CNYPC, he returned to the SHU at Wende, and was given the medications Celexa, 20 mg. per day, and Vistaril, 250 mg. at night. Diagnoses on his outpatient chart matched those on the Discharge Summary from CNYPC. On 11/9/01, Sinequan 150 mg. was added to his

medications. He was noted to be complaining of depression, insomnia, and visual hallucinations. On 11/09/01 he is diagnosed on outpatient progress notes with Major Depressive Disorder with Psychotic Features.

A disciplinary hearing commenced on October 10, 2001. It appears from the transcript, that this prisoner may have been incompetent to represent himself at that proceeding. As part of the proceeding the hearing officer heard confidential testimony from mental health staff regarding this prisoner's mental condition. According to the Memorandum Decision, dated 11/14/02, the hearing officer asked the mental health employee "He has stated that he doesn't recall any of this incident. Would that (be) part of the psychiatric disorder?" The witness responded: "No, it doesn't appear to be. Central New York Psych. Center's report is that they are under the impression that he is malingering and that he is not experiencing these symptoms he verbally reports, he didn't experience any psychotic episode." As a result of the hearing, this prisoner was punished with ten years in isolated confinement.

I reviewed this prisoner's file and gave a report to the hearing officer that included these points:

1. This prisoner has a lifetime history of serious mental illness, with relatively intensive treatment, including psychotherapy and fairly strong dosages of psychotropic medications since at least 1995 and throughout his current term of incarceration.
2. There is evidence that he experienced "blackouts" dating back to at least 1992 (prior to this term of incarceration), as noted in a chemical dependency assessment done in 1992.
3. There is no mention of manipulation or malingering in the charts I reviewed until 6/9/99.
4. The dosages of antidepressant medication (Prozac, 60 mg. per day – where the standard dosage is 20 mg. per day) and anti-anxiety medication (Vistaril as high as 250 mg. per day), plus the additional prescription of Sinequan, an anti-depressant with tranquilizing effects, at 300 mg. per day – all of these unusually high dosages of psychotropic medications indicate that clinical staff believed that he has been suffering from a severe and bona fide mental illness throughout his incarceration.
5. While Dr. John Wilson discusses malingering in his report of psychological assessment (9/25/01) during this prisoner's inpatient admission to CNYPC, his report also reflects that he diagnosed very severe forms of mental illness. Dr. Wilson also diagnosed severe character pathology, difficulty in regard to reality testing, severe regression and reliance on primitive defense mechanisms such as splitting, projection and projective identification.

6. During the same admission to CNYPC, two psychiatrists declared that this prisoner's mental illness qualified him for civil commitment and several psychiatrists prescribed anti-psychotic medication at relatively strong dosages (Risperdal, 4 mg. per day), supplemented with two anti-depressants (Celexa and Sinequan) and a relatively strong dosage of an anti-anxiety agent (Vistaril).
7. The combination of these dosages of three categories of psychotropic medications constitutes a relatively strong psychiatric medication regimen.
8. Other than Dr. Wilson's isolated report, there is no mention of malingering in this prisoner's Inpatient chart.
9. Even after Dr. Wilson's report was in the chart, the psychiatrist's diagnosis upon discharge from CNYPC was Major Depressive Disorder with Psychotic Features; and that same diagnosis, Major Depressive Disorder with Psychotic Features, appears on the outpatient progress notes following this prisoner's transfer back to the SHU at Wende. There is no mention of the possibility of malingering in either place.
10. Psychiatric medications were prescribed after he was returned to the SHU at Wende.
11. While a psychological assessment, such as that done by Dr. Wilson, is useful in determining the full extent of a prisoner's psychological problems, the fact that one psychologist determines malingering, among other forms of psychopathology, is present, does not negate all the other diagnoses and treatments at the hands of various other professional clinicians.
12. In fact, the long record of diagnoses and treatment at the hands of many clinicians makes it extremely unlikely that this prisoner is "merely malingering." He might manipulate to some extent and on some occasions – many individuals suffering from serious mental illness do so, especially where mental health services are in short supply – but it would be extraordinarily unusual for a manipulative person with no serious mental illness to fool a large number of clinicians over many years – and to continue to fool them so that they would diagnosis severe depression with psychotic features where there is no mental illness.
13. Similarly, it would be extraordinarily unusual for a large number of clinicians to continue to prescribe psychiatric medications even after a psychologist makes the diagnosis of malingering, if there were no mental illness
14. The more likely explanation of Dr. Wilson's findings are that this prisoner suffers from bona fide serious mental illness and presents a complex clinical picture. Dr. Wilson focused on one aspect of that complex clinical picture while other clinicians decided it was more important to focus on the depression, anxiety and psychosis that were making this prisoner so dysfunctional.

15. It is quite possible that this prisoner's complex psychiatric disorder played a significant part in his actions on July 29, 2001.
16. It is quite possible that his psychiatric difficulties contributed significantly to his rule-violating and violent acts on those occasions, or that his mental state was impaired to the extent that he was incapable of forming the requisite intent.
17. It is quite likely that the reason this man has had to be prescribed such high dosages of psychotropic medications is that the long stints he has spent in isolated confinement have intensified his anxiety and rage and caused psychiatric breakdown, which the mental health staff have been trying to control by increasing medication dosages.

As of Dr. Shimkunas' deposition on 6/3/04, this prisoner was in SHU at Wende, approved for STP, and had been waiting months to be admitted to that program.

Example of:

SMI in SHU

Deteriorating Condition in SHU

Cycles from SHU to observation & CNYPC and then back to SHU

SMI involved in disciplinary infraction

Long wait to be admitted to STP

G. F.

(Interviewed while housed in SHU).

G. F. has been in SHU a very short time. He takes medications for Depression and voices. He has cuts on his wrists, and reports he has been in psychiatric hospitals six times because of command hallucinations. Command hallucinations tell him to cut himself, and then he receives a ticket and is sent to the box. He is lethargic in his SHU cell, and sits and reads the Bible. He seems to be suffering from Major Depressive Disorder, Recurrent, with psychosis and multiple suicide attempts. He has been prescribed Haldol and Thorazine, but he thinks he now receives Zoloft and Seroquel. Medications usually help make him feel better when he is in any other situation, but in SHU they do not help at all. He would like to go to STP, but he says "Nobody helps me." His clinical chart contains an 11/26/02 diagnosis Depressive Disorder NOS & Psychotic Disorder NOS. He sometimes refuses medications, or is prescribed Haldol, Zoloft, etc.

Example of:

SMI (Depression with Psychosis) in SHU

Self-harm in response to Command Hallucinations

Tickets for self-harm

Inadequate treatment, given severity of condition

E. E. N.

(Interviewed while housed in observation).

E. E. N. has many scars from cuts on his face, some recent. He is seen while in observation, where he has been for two days. He had been in GP, but has been on Keeplock since June. He tears fixtures and lights in his cell and then cuts his face. He also sets fires. He had a long psychiatric history prior to incarceration, from age nine, including many admissions to the Bellevue psychiatric ward. He was declared incompetent to stand trial at one time and sent to Mid-Hudson psychiatric unit, where he was restrained on a bed and injected with involuntary medications. He was in ICP until last January, when he left to re-enter GP. He is prescribed Zyprexa, Lithium and Trazadone, and says the medications help him. He is called out of his cell to see a mental health worker every two weeks. He likes to cause trouble for guards. He does not remember his commitment offense. He says he suffers black outs, and can be violent. He was abused as a child in a home with much alcohol abuse. He gets into rages and then has black outs and memory loss for the incident. He says he does not know why he does the violent things he does, he is "not afraid to die" (on further questioning he admits he thinks he is already dead). He tells me he is going home soon. He says he used to hear voices, but does not experience hallucinations when he takes his medications. His clinical chart contains a 2/7/02 diagnosis of Psychotic Disorder NOS and an 11/13/03 diagnosis of Bipolar Disorder, Hypomanic recent episode. He is also diagnosed Impulse Control Disorder, PTSD, polysubstance abuse, ASPD & Borderline Personality Disorder. A history of serious mental illness from childhood is noted, he is prescribed Zyprexa 5 mg. And Depakene 1500 mg. on 11/21/02, but interestingly on that date no diagnosis of psychosis or Bipolar is entered. He has been in ICP and GP, and in May, 2002 he was in GP with a diagnosis Psychotic Disorder NOS and prescription of Zyprexa 15 mg. and Depakote 1500 mg. In other words, the clinical chart corroborates his history, he suffers from SMI and it is worse in SHU. He should not be in SHU.

Example of:

SMI (Schizoaffective vs. Bipolar) in SHU

Deteriorates in SHU

Cycles from SHU to observation & CNYPC and back to SHU

Z. J.

(Interviewed while housed in observation).

Z. J. is seen in a Ferguson gown and is in observation at Wende Correctional Institution. He has been in prison for six years. He came from the Southport SHU, where he has been for three years. He has received eight tickets, most while in SHU. He believes that in SHU, the COs have nothing to do, so they harass the

prisoners and then write tickets. He complains of being starved by staff while in observation, and he says he has a lawsuit about staff beating him while he was in observation. He dropped out of school in the 11th grade. He was sent to observation two days ago, when he told a social worker he would kill himself if they kept him at Wende. He is prescribed Zoloft and Depacote – staff feel he has anger problems. He is very concerned that if sent back to Southport, where COs have a grudge against him and there is no mental health service, he will kill himself by hanging up. I alerted the psychologist, Dr. Tony Devito, at Wende about this concern, which I believe is credible. He has not been admitted to CNYPC. He has been in observation three or four times, each time returning to SHU upon discharge. In September, 2002, he was in observation for 14 days, half at Upstate and half at Clinton. He wants to be in the satellite unit, but staff keep sending him to a SHU where there are no mental health services. He is not certain if he hears “voices,” he knows he talks to himself quite a lot in SHU. He also suffers from “shaking,” worse in SHU, especially when it’s cold. He avers some ideas of reference in SHU, for example if he hears a whistle he thinks they are whistling at him. On mental status exam he is intense, scared and depressed. His eyes are directed downward. There are some vague ideas of reference but no clear hallucinations nor delusions. His clinical chart contains many OMH admission sheets with diagnoses deferred or blank, on 9/16/02 he is given a diagnosis of Impulse Control Disorder with ASPD and a GAF current 55, best in year 65, at which time he was again being screened by CNYPC for suicide risk. It is noted he has substance abuse problems, and no sexual trauma. He repeatedly cycled between Upstate (single cell) and observation at Wende or Clinton when he becomes suicidal. But he is not diagnosed except Conduct Dis and ASPD until 10/03 (after we see him), when he is moved to Southport, Level 2, and prescribed Zoloft, Trazadone, and later Depacote; and by 1/04, he is prescribed Depacote and Vistaril and preparing for release from prison. In summary, this man with significant mood disorder had been housed at Upstate where there was not adequate mental health level of care, and cycled many times to observation at Wende or Clinton before being transferred to a facility, Southport, where he could finally be prescribed antidepressant and mood stabilizing medications. Prior to that time, he was viewed as manipulative by staff, who kept returning him to Upstate where he would become suicidal anew and have to cycle to observation.

Example of:

SMI (Depression) in SHU at Southport

Inadequate mental health services

Cycles from SHU to observation and CNYPC and back to Southport SHU

Under-diagnosed

I.T.

This interview was very brief because he speaks no English. His chart reflects he was in RCTP with a Diagnosis of Schizo-Affective Disorder on 8/6/02; he was returned to SHU from RCTP on 6/14/02, and he has multiple CNYPC admissions with diagnosis Schizo-Affective Disorder. Old chart has diagnosis Schizophrenia, Undifferentiated

Type, prescription of Haldol, and pre-incarceration psychiatric hospital admissions. A 6/19/02 Outpatient Core Evaluation summarizes: "The patient has a history of six admissions to CNYPC; the most recent hospitalization was from 10/12/99 to 11/10/99. All admissions were due to poor medication compliance, which resulted in decompensation. During these periods of decompensation, the patient becomes grandiose, paranoid, agitated, verbally abusive and can be dangerous to himself or others.... Recently he is alleged to have assaulted an officer and was placed in SHU for one year. He is refusing medications and feels he can do well without it...." The note goes on to say he cannot have rehabilitation because there is none in SHU, he is not currently psychotic by mental status, and he agrees to request medications as needed. In other words, he suffers from SMI and repeatedly cycles from SHU to CNYPC and back to SHU. There is no notation to suggest that OMH participated in the disciplinary hearing process when he was consigned to SHU. From then on he was seen on SHU rounds only, and intermittently prescribed Risperdal 2 mg. twice per day, sometimes refusing medications, as reflected in progress note of 3/5/03. His diagnosis remained Schizophrenia, Undifferentiated. This man suffers from Schizophrenia and spends long periods in SHU, where he periodically decompensates. He should be removed from SHU and placed in a treatment program such as ICP.

Example of:

SMI (Schizophrenia) in SHU

Deteriorates in SHU

Cycles from SHU to observation and CNYPC and then back to SHU

Not followed closely, & likely is psychotic much of time in SHU without detection

Q. H. (Interviewed while housed in B Block, Company 99).

Q. H. has been in prison since 1998. There was much disagreement about his competence to stand trial, and many psychiatric evaluations. He has a long history of serious mental illness and psychiatric medications. He was in ICP in Sing Sing for seven or eight months, and graduated to GP. After being discharged from ICP, he tried to kill himself twice. He became paranoid after halting his psychiatric medications at Eastern Corr. Inst. He has not been to SHU and has no tickets. He went to CNYPC in 1986 or 1987 because of self-harm. He exhibits tardive dyskinesia, he avers hearing voices, he is receiving mental health treatment but feels it does not help. On mental status exam he is disoriented as to time, affect is flat, he speaks rapidly and is unable to abstract. He describes the "strip cell" where you are naked and it's cold. He believes they are "messing with my food" on B Block. He is Jewish and wears a yamulka, and he takes psychiatric medications. He is on B Block, Company 99, where there are a lot of prisoners with mental illness. This man presents a clear picture of chronic Schizophrenia; he exhibits tardive dyskinesia, is in GP, Company 99, and is receiving mental health treatment.

Example of:

Chronic Schizophrenia on Company 99, GP, in outpatient treatment

F.X. (Interviewed while housed in B Block, 99 Company).

F.X. has been in prison for 13 years of a 22-to-life term for murder. He is housed on B Block, 99 Company – he reports that 13 or 14 of the 16 prisoners on that company suffer from serious mental illness. He has been at Wende since 1998. He expresses complaints about COs; for example they say “If you don’t like it, then go cut up.” He had a long psychiatric history prior to incarceration. He complains that the COs breach his confidentiality by talking about him with each other. He is not receiving mental health treatment presently, and states that mental health staff do not intervene with officers or hearing officers if prisoners with SMI get tickets. He has been to CNYPC nine times, and has been to SHU only once on this bit. He does not tell mental health staff how he is feeling because he is afraid they’ll throw him in a strip cell. He does not like ICP because “there are no programs over there.” He shows us scars on his forearms from previous cutting episodes. He is afraid of groups/crowds, and gets paranoid around others. He suffers from severe depression and hears voices. He is visited by his wife and daughter and feels supported. He was in Special Education until the tenth grade. He was always “hyper” as a child. His chart contains diagnoses of Adjustment Disorder and Depressive Disorder NOS with Borderline Intellectual Functioning. Multiple CNYPC admissions for self-injurious behavior that occurs when depressed. On 5/5/03 a diagnosis of Bipolar II was recorded. Medications include Zyprexa 20 mg./day and Lamictal, 300 mg./day. He seems to do well with outpatient support on these medications in Company 99.

Example of:

Chronic SMI, probably Schizophrenia, possible MR, in GP, Company 99

Receives outpatient OMH treatment

Many admissions to observation and CNYPC

Attica Correctional Institution – 9/23/03

D.U. (Interviewed while housed in SHU).

D.U. has been in prison two or three years this bit, and did four years previously. He has been in SHU for one year because he fought with another prisoner, and then in SHU he threw a bottle of pills at a nurse and received a longer SHU term. He finds himself yelling at staff, and then he gets more tickets – all because of the pressures of the SHU. He has been in mental health treatment since 1984, with a diagnosis of Bipolar Disorder. He was taking medications, including Risperdal and Artane. When he was a teenager in California he was admitted to Napa State Hospital and Langley Porter psychiatric unit. When he does not take medications such as Risperdal, he cannot sleep and he gets agitated and paranoid. He shows many fresh cuts on his arm, and says when he does not hear from home he gets paranoid and cuts himself. He has Hepatitis C. He

denies being suicidal, but cuts to see blood. He has been to observation two or three times, and admitted to CNYPC two or three times. He would like to be in STP. He says he cuts himself to avoid hurting someone else, and he feels better after cutting. He typically sees mental health staff for five minutes at cell front. He gets anxious and cries when in SHU, and he feels suicidal. Interferon makes him too depressed. He is behind lexsan, and hears his neighbors screaming a lot. On mental status exam he exhibits an intense and bizarre stare. He thinks the COs harass prisoners with mental illness. He does not go to yard for fear of run-ins with COs. He says mental health staff merely say "hi" as they do rounds, and don't talk to prisoners with mental illness in SHU. And they do not intervene when a prisoner with SMI gets a ticket. His clinical chart is consistent with the history he presents. From 1992 his diagnosis has shifted from Impulse Control Disorder to Adjustment Disorder or Axis II problem. But notes reflect anxiety and depression when in isolation. In May, 2002, he was prescribed Risperdal, and on 4/30/03 he was prescribed Seroquel 400 mg. A 7/23/03 Treatment Plan Review notes a diagnosis of Mood Disorder NOS. He has been prescribed Vistaril and Sinequan in the past, but at other times Trilafon, Haldol and Prolixin (anti-psychotics). A 2/1/04 review notes he is ticket-free, but he manipulates to get the medications he wants. Medications in this period include an antidepressant (Paxil or Wellbutrin) and Atarax (minor tranquilizer). He has received other tranquilizers in the past. The diagnosis Mood Disorder NOS continues through late 2003. But clearly there are also psychotic features or psychosis, and this is not noted in the chart even though symptoms of paranoia and thought disorder are cited and anti-psychotic medications are prescribed. This man clearly suffers from chronic psychosis and depression, and deteriorates in SHU where he is now. He also cycles to observation, CNYPC and back to SHU. He needs to be out of isolation and in a treatment setting such as ICP.

Example of:

SMI (Depression, Psychosis) in SHU

Deteriorates in SHU

Cycles from SHU to observation & CNYPC

Under-diagnosed

S.J.

(Interviewed while housed in SHU).

S.J. has been in prison for three years this term. He was sentenced to Willard (low security drug program), he threw a tray and was sent to Five Point SHU, where he got in a fight and was eventually sent to Attica SHU. He was admitted to CNYPC for 30 days so that his psychiatric medications could be regulated. He now takes Depokene, Neurontin and Seroquel. On June 13th, he was discharged from CNYPC to the Attica SHU, and had a fight on the bus which earned him a longer SHU term. He definitely feels that his mental illness causes him to get into fights. He wears sunglasses at night to disguise himself so that the people observing him will not recognize him. He has been in STP before, and likes it. He was sent to observation last night because he tried to hang up. He had a psychotic episode at Five Points, replete with hallucinations. He was told he could go to ICP, but they never let him go. When they did a telemedicine

conference, he requested candy and pizza. His medications are discontinued periodically and his condition becomes worse. When he got his last ticket for fighting, the hearing officer did talk to mental health, but that didn't help. He says he is manic, and that is why he cannot control his temper. The pattern is that when he becomes psychotic he gets into trouble. He has been to observation at various institutions, and to CNYPC once. He's angry because he feels he should be out of SHU, but he got a bogus ticket. He did not go to his hearing. He believes he should be in ICP. When he is in a less pressured setting, he slows down and can control his temper. He has cut himself and tried hanging up. He says he wants to die. He also burned himself on the stomach in response to command hallucinations – the voice of God told him to sacrifice himself for God's sins. He received his GED at 17, and has a drug problem. He started drug treatment in DOCS, but never finished. On mental status exam he displays pressured speech, agitation, bizarre and intense facies, flight of ideas, and inability to slow down when asked, and ideas of reference. He says he cannot sleep without medications. His clinical chart is consistent with the history he presents. An admission note for 5 Points MHU has diagnosis Schizoaffective Disorder. His progress notes at 5 Points and Attica reflect outpatient treatment and MHU treatment for mood disorder and hallucinations. He was admitted to RCTP on 5/2/03 for waving a blade, threatening self and others. He had to be taken down and sent to RCTP. On 5/15/03 he was admitted to CNYPC for the first time. He was felt to be manic. He was placed on SPL1 behavior treatment plan that lasted from admission until 5/25/03. He was on SPL1 again in early June, and was discharged from CNYPC on 6/12/03. He was taking Depakene 750 mg. b.i.d. and Seroquel 400 mg. b.i.d., but his primary diagnosis was Adjustment Disorder with additional Dx Intermittent Explosive Dis., Schizoaffective Disorder, ASPD and substance dependence. While he was placed on "Behavior Management Restrictive Intervention Monitoring Form" and monitored or restrained while at CNYPC, there was no psych testing and no Behavior Management Plan (in the chart) that would follow him upon his return to SHU. There was a recommendation at CNYPC that he go to STP. Medications include Zyprexa, Risperdal, Mellaril, Depacote, Neurontin, etc., at different times. He is basically seen cell-front in SHU and medicated, with ongoing notes about command hallucinations and bizarreness, and he is repeatedly sent to RCTP for frank psychosis and danger of harm to self or others, all at the behest of command hallucinations. In summary, this man is severely disturbed, likely diagnosis Bipolar Disorder with Psychotic Features (or R/O Schizoaffective), is not adequately medicated and should not be in SHU. His mental illness definitely informs his misbehavior. He should be in ICP or equivalent treatment setting.

Example of:

SMI (Schizoaffective) in SHU

Deteriorates in SHU

Tickets driven by SMI

Cycles from SHU to observation & CNYPC and then back to SHU

Inadequately treated

Recommended for STP but not sent there

F.F.J.

(Interviewed while housed in SHU).

F.F.J. has been in prison 15 months this term. He had left prison in 2000 but returned on a parole violation. He is depressed and anxious, but says he cannot get mental health treatment because he is not psychotic. He has a terrible time in SHU, where there is constant banging, yelling, and he cannot escape the noise. He gets anxious, and he thinks he gets into fights in order to escape the anxiety. He has asked for mental health treatment, but all they do is talk to him through his cell door. He claims that prisoners with serious mental illness are abused in SHU – if you do anything wrong, they put you on loaf. He has been put on loaf erroneously. On mental status exam, this man is coherent and not psychotic, but he is clearly depressed and anxious. His chart contains reference to depression, diagnosis Adjustment Disorder with Depressed Mood, no meds, little contact, MH Level 6.

Example of:

SMI (Depression) in SHU

Not receiving OMH treatment

Depression worse in SHU

Under-diagnosed, mental health level inaccurate

D.T.

(Interviewed while housed in SHU).

D.T., serving a life sentence, has been in prison for nine years and in SHU since May 20. He has spent three years in SHU altogether. In SHU, for the least problem, the whole gallery starts banging on their plexi-glass. He is prescribed Trazadone for depression. He mostly sits in his cell and talks to himself. He took a murder bit for his uncle. The first seven years he was in prison he didn't care about anything, and was very angry. When he set fire to his cell he was sent to SHU. At 18 years, he tried to shoot himself through the mouth. He lost part of his brain and the front of his skull (scars and misshaped skull obvious). He has seizures. He has tried to kill himself by OD twice in prison. He goes to a strip cell for approximately nine days, then back to SHU. He tells me he beat the arson charge – it was suicide. He was in ICP for a year at Clinton. He is depressed and psychotic, he tells me. ICP was a good place for him. He fears he cannot survive in GP. He tries to read, but cannot concentrate. His clinical chart is consistent with the history he presents. His diagnosis is Impulse Dyscontrol Disorder with anger and self-harming behaviors, a history of serious suicide is noted, he has a pre-incarceration history of psychiatric admissions for suicide attempts.

He transferred from Southport to Attica 12/2/02. He was prescribed Zoloft 100 mg./day. He had been prescribed Haldol and Cogentin in 1996, and later, Seroquel. He has also been diagnosed Dysthymic Disorder, Psychosis NOS and PTSD. He had a trial of ICP in 6/02. He was in STP in 9/03. In summary, this man has a severe head injury with frontal lobe loss and resulting organic impairment, he is impulsive, self-destructive, depressed and possibly suffers from psychosis. He needs to be in a protected mental health treatment setting such as the ICP.

Example of:

SMI (Depression, Organic Brain Syndrome) in SHU

Had done well in ICP

Cycles from SHU to observation and CNYPC and then back to SHU

Albion Correctional Institution – 9/24/03

Y.B.

(Interviewed while housed in SHU).

Y.B. has been in prison for seven years. She was paroled in Feb., 2003, and then violated & returned in July. She will be released in November. She had been housed in SHU for five months at the time of our meeting. She has received 70 tickets during her term, and had spent time in SHU previously. She has a long psychiatric history, beginning with an inpatient stay at Jaccoby Hospital at age nine years, when she was prescribed antidepressant and anti-psychotic medications. Her mother was an alcoholic. She was in Special Education. She has been hearing "voices" since age nine. She received a ticket today, she says it was written by an officer who regularly "sets women up for bogus tickets." She reports that prisoners suffering from mental illness are treated badly. She reports that while she was being brought to the room where we interviewed her, the officer told her to tell us that she was not hearing voices, that she does not want to kill herself, and that she is being treated well in the SHU. She also complains that the officers in the SHU think it is funny that she takes psychiatric medications. She complains of frequent flashbacks to rapes that occurred around the age of ten. On mental status, she is very depressed with psychomotor retardation and describes a consistent picture of Major Depressive Disorder with Psychotic features. She explains there is a marked intensification of her depression when she is placed in SHU, with even more severe depression as the time in the SHU lengthens. She cries as she tells us that she feels more and more like "nobody cares" when she is left alone in the SHU. Her depression worsens. She reports that in the SHU she feels "very claustrophobic," she hears the voices of people calling to her, she feels the walls are closing in on her, she gets very confused and cannot concentrate, and she has a very difficult time controlling the rage that grows within her. She complains both that male officers can and do watch her undress and go to the bathroom, and yet when she needs help and calls out, nobody responds to her requests. She describes the "strip frisk" that occurs when she is taken to observation, and reports on an incident a few months ago when she resisted the attempt to strip her because she was feeling very paranoid and unsafe, and "they jumped me." A

woman C.O. cut her clothes off while male C.O.s were in the room, and she complained about this. She has been taken to observation four times, all four times from the SHU, and after she spent several days to a week in observation she was returned to the SHU. She was not transferred to CNYPC nor the MHU at Bedford Hills on any of these occasions, however she had been at Bedford Hills earlier. In her chart there are notes from Bedford Hills, she has been diagnosed with Depression and Posttraumatic Stress Disorder, a long history of serious mental illness and psychiatric hospitalization prior to incarceration is noted, and she has been prescribed Seroquel (anti-psychotic), 500 mg. per day, and Paxil (antidepressant), 60 mg. per day for the period July through October, 2003. She has also been prescribed Risperdal and other medications. A 12/12/02 RN's Progress Note of a private interview while prisoner is in SHU: "She also reports having panic attacks. Pt. Upset because the Lt. lied about her. She says he grabbed her by her hair. She says she froze up and had a flashback. Pt. Reports that she feels pressure building up and at times feels like she wants to die. Pt. asking for a medication evaluation. Discussed procedure for getting a cross gender pat frisk exemption." A 5/21/03 Progress Note states: "Pt. tearful. Felt she was treated unfairly during transfer to OBSO. 'I hurt myself. I hit my head as they were bringing me into the cell.'"

Example of:

SMI (Depression, possible psychosis) in SHU

Deteriorates in SHU

Past trauma history

Traumatized by searches, move to observation

Cycles from SHU to observation and then back to SHU

B. N. (Interviewed while housed in SHU).

B. N. has been in prison for three years, convicted of cashing a bad check, and has been in SHU at Albion since July 17 for a ticket that she says was given to her by an officer who she had cussed only after he had cussed at her. She thinks she has spent more time in SHU than in General Population. She reports a beating she received at the hands of officers on September 26, 2001, which resulted in head trauma. On another occasion, she was ordered by an officer to walk to the Administration Building one evening. She felt she was unable to do so because her legs were hurting and she was afraid to walk that far at night. An officer and a Sergeant came to her cubicle to get her, and demanded that she give them her identification. By mistake, she picked up a picture of her daughter and gave it to them. They got angry at her because she failed to produce her identification. She became angry and asked for her daughter's picture back. She believes that officers give her tickets in retaliation for her lawsuits. She has pulled her hair out since childhood, and reports she received on ticket for trying to color her hair to disguise the hair-pulling. She reports that immediately after being released from SHU she feels disoriented, scared and confused in General Population. She says she suffers from "nerves," she becomes confused when she is housed in SHU, and she hears the voice of her baby crying. She had been admitted to a psychiatric hospital in the community prior to incarceration because she was depressed, tried to harm herself, and

was experiencing auditory hallucinations. In SHU she "hears things," for example she wakes and finds herself answering out loud an imaginary voice. Or she sees shadows running around in her cell. She is prescribed Haldol, Cogentin and Vistaril. She reports that if one is suffering from a mental illness in the SHU, "the officers laugh at you, make jokes about you, and write you tickets more often." She received six tickets while in SHU, the one for trying to color her hair, another for arguing with another prisoner on the yard, etc. She believes time in SHU has destructive effects on her mental state. She becomes scared, lonely and sad, and worries that they (officers) will do something to her "stuff." She receives visits from her mother and children, ages 13, 15 and 17. On mental status, this woman exhibits very depressed affect, psychomotor retardation, low self-esteem, and hopelessness about her future. She takes psychiatric medications some of the time and not at other times. She started taking the anti-psychotic medication, Haldol, once again a week prior to our meeting. She notices that when she is not taking her medications she is easily provoked and gets into arguments with officers. When asked if the hearing officer takes her mental illness into account, she says they say they do not care about her mental illness. She describes episodes when she gets confused and dysfunctional, and then something goes wrong between her and an officer and she is given a ticket. Her clinical chart contains diagnoses of Trichotillomania (compulsive hair-pulling) and Depressive Disorder, with earlier (February, 2003) entries mentioning Bipolar Disorder and Panic Disorder. She is prescribed Haldol (including Haldol decanoate, 50 mg. per month, plus p.o.), Prozac (40 mg.), Trazadone (200 mg.) and Cogentin. There are notes about pre-incarceration domestic violence, obvious sadness during counseling sessions, and a history of Attention Deficit Disorder with Hyperactivity. Clearly this woman is severely depressed and experiences intermittent psychotic episodes, may suffer from Bipolar Disorder or other SMI, is taking strong antidepressant and anti-psychotic medications, and should not be in SHU because isolated confinement worsens her emotional disorder.

Example of:

SMI (Depression, psychosis, R/O Bipolar Disorder) in SHU

Deteriorates in SHU

Receives more tickets in SHU

Claims bad treatment by officers

H.U.

(Interviewed while housed in SHU).

H.U. has been in prison for close to four years for second degree burglary, and expects to be released in a year. She was sent back to SHU only yesterday, for inmate-to-inmate correspondence, and though the hearing has not occurred yet she believes she will be given a seven month SHU term. She is starting to think there is a conspiracy: while she has not informed on anyone, she thinks the staff believe that she informed on an officer who is having an inappropriate intimacy with an inmate. She has told OMH staff that she fears for her life while at Albion because of this conspiracy. She confides that she is depressed, and is prescribed Prozac and Seroquel and Depacote (this list of medications indicate more severe psychiatric problems such as a psychotic

condition and/or Bipolar Disorder). She describes recurrent depressive episodes wherein she isolates herself for weeks at a time, spends most of her time in bed, cries a lot and has no energy for anything. In response to my question whether being in SHU has an effect on her psychiatric condition, she responds it certainly does: either she gets more depressed in SHU, or, because she feels invincible (I suspect she is describing the upward, manic or hypomanic part of a mood swing here) and she gets into more trouble with the officers. Her hands tremble when she is in SHU, she feels like the walls are closing in on her, she sleeps much too much, she has difficulty concentrating, and because the women in SHU are not permitted to speak to women in adjoining cells or even in other recreation cubicles when at "rec," she feels dreadfully isolated and this worsens her depression. She reports being strip searched with male officers present in the SHU, and tells us that she is strip searched when she goes to visits while in SHU. Her clinical chart is consistent with the history she presents. Her diagnosis is Major Depressive Disorder on 1/31/04, but on 1/19/01 Bipolar Disorder is diagnosed. Her medications are confirmed except there is no notation about Depacote. Two earlier suicide attempts are noted, no attempt in DOCS. She receives outpatient therapy only.

Example of:

SMI (depression, R/O psychosis, Bipolar) in SHU

SHU term for inappropriate correspondence

Deteriorates in SHU – manic and depressed

Fears for life because of (real or imagined) conspiracy

L.G.

(Interviewed while housed in General Population).

L.G. has been in prison for five years and goes to the (parole) Board in November. She was in General Population when we interviewed her, but she had been in SHU from December, 2002 through March, 2003, and then from April through July, 2003. She suffers from both a medical condition and a mental illness: depression. She reports that hearing officers do not consider her mental illness when meting out punishments. She has attempted to kill herself three times while in prison, once at Bedford Hills, once by overdose while in SHU, and once while in the Infirmary for a medical condition. In December, 2002, she tried to cut herself and was transferred to a Bedford Hills observation cell. She has been placed in an observation cell many times at Bedford Hills and three times at Albion; in each case she was sent to observation from SHU and then was transferred back to SHU. In SHU, she is not permitted to talk to anyone, or she gets a ticket, and she finds the social isolation very distressing. She explains that a prisoner in SHU must be at her door, dressed, or she misses meals or recreation or shower – but when a prisoner is taking psychiatric medications it is difficult to pay attention and be at the door at the right time. She has received approximately 25 tickets while in SHU, "because the C.O.s hassle you, for instance they say you were talking when you weren't, many more tickets are given in SHU than GP." She finds the strip searches that precede placement in SHU and placement in observation very dehumanizing. She tells me: "At least at Bedford Hills you get pajamas; here, it's a paper gown, and there are male C.O.s standing around; at least at Bedford Hills they give

you a strap for your menses, not at Albion" (several women reported that they are given a pad with no strap to hold it in place.). She has been left in observation naked for 72 hours. She finds it very degrading to have to use the toilet with male officers observing her. And, she reports, on most days nobody from mental health comes to talk to her when she is in observation – a nurse does visit her briefly to give her medications. She is not receiving mental health treatment at present, in large part because she finds it is quite difficult to get the attention of the mental health staff when they make rounds in SHU. She complains that getting her medications is very problematic. First, she has to wait in line with hundreds of women to receive her daily psychiatric medications (that line is in the mess hall), and then she has to wait in a line that is not as long to get medicine for her medical condition. She has to use up all of her time for recreation standing in line waiting to receive medications. The fact that in the SHU she is issued used clothes, previously worn by other women, makes her feel more depressed. She has trouble getting along with the other prisoners at Albion, she thinks this is because she has enemies in the institution. She has received 40 tickets, she believes most are due to the fact that her mental illness causes her to have insufficient control of her impulses. On mental status exam, she is agitated as she describes depression, low self-esteem, worthlessness and rage that comes out when she feels she is being treated unfairly and cannot do anything about it. Her clinical chart includes diagnoses of Depression and Psychosis NOS (1/28/03). Prescription of Seroquel (600 mg. per day) and Zoloft (100 mg. per day). There is also mention of Impulse Control Disorder, a seizure disorder, antisocial personality disorder, and a 4/9/01 note about paranoia.

Example of:

SMI (Depression, possible Psychosis) in GP now, was in SHU

Cycles from SHU to observation & back to SHU

SHU worsens despair, suicide attempts

Explains how prisoners with SMI miss showers and recreation

Many tickets, likely driven by SMI

R-E

. (Interviewed while housed in General Population).

R-E

has been in prison since December, 2002, with a former term of two and a half years – most of her time has been spent at Bedford Hills. She is in population, having just finished a term in SHU. She is at Albion because of alleged inappropriate relations with a Sgt. at Bedford Hills. She completed the tenth grade, worked as a secretary, and has a 12 year old son. She received a three day SHU term, and then another 43 day term once in the SHU because of an argument she had with an officer. She has had other tickets. She claims her mental health problems are minor, but she has a history of auditory hallucinations with depression, and she has been suicidal. She was admitted to Jaccoby psychiatric hospital in the Bronx prior to this term, and was treated with antidepressants and Haldol. She reports she was prescribed Seroquel and Haldol for equivalent symptoms while incarcerated at Bedford Hills. She describes two incidents when she was taken to observation at Bedford Hills against her will – on one occasion the chair she was sitting in was lifted by staff and she was carried there. She did

not find the strip searches abusive. She never received a SHU term at Bedford Hills, but since arriving at Albion she has received 30 day Keeplock terms and has been immediately sent to SHU to serve the terms. She relates that she feels pressured by the time in SHU, and her emotional symptoms become worse. She is not currently taking medications, having discontinued them herself. She describes the routine in SHU, including the fact that if one is not "on the door" one misses recreation, showers, and even meals. She believes that prisoners with mental illness are especially prone to miss recreation, showers and meals, because they are too disorganized to get to the door when they are supposed to. She provides observations about Maria Rosato, and points out that officers tend to ignore her in spite of her seizures or black-outs. She observes staff saying mean things to prisoners suffering from mental illness. She says, in general, "the COs in SHU disrespect you to the point where you can get a ticket." She describes strange experiences in the SHU, including the conviction that a man was present in her cell, even hugging her, and then she "bugged out." She reports that several prisoners, including some suffering from mental illness, are inappropriately involved with officers. Her clinical chart is entirely consistent with the history she presents. She had been hospitalized at Children's Hospital for a suicide attempt prior to her first bit in DOCS. She has been prescribed Haldol and Seroquel. Her diagnoses include Depression, Mood Disorder, PTSD and Substance Abuse. On a 3/23/03 "Trauma Assessment Form" a large amount of physical and sexual abuse is noted from childhood, including adulthood (attempt molest by M.D. at Jaccoby Hospital prior to incarceration) and within DOCS. Mental Health Level varies from 6 to 1. Medications include anti-psychotic (Risperdal), mood stabilizer (Neurontin), antidepressant (Paxil) and minor tranquilizer (Klonopin). There are many outpatient "no shows" for medications. There is a 12/19/02 note with diagnoses Mood Disorder, substance abuse and PTSD, another diagnosis of PTSD 8/25/03, and a 2/19/03 notation: "...may benefit from continued psychotherapy and psychiatric medications to assist in managing historic abuse issues and experience with depression and related auditory hallucinations." Yet, from progress notes, it seems not much psychotherapy occurred – disappointing, given the severity of her trauma history. She has been admitted to observation and has spent time in SHU.

Example of:

SMI (Depression, likely psychosis, PTSD), was in SHU

Depression worse in SHU

Minor ticket led to SHU, then gets more tickets in SHU

Describes loss of showers and rec if suffering from SMI

History of multiple traumas, therapy recommended and never offered

G.J.

G.J. has been in prison for three years and has five-to-15 years to serve for manslaughter. She suffers from kidney failure and PTSD; she was on the OMH caseload but is no longer. She experiences tingling in her left arm, and weakness. She was in psychiatric hospitals twice for suicide attempts prior to incarceration. At Bedford Hills she received mental health treatment but was never comfortable talking to her therapist.

She witnessed another prisoner set herself on fire last May and this traumatized her. She is unable to sleep and has recurring images of the girl screaming. She is very anxious, fearing that when she has an emergency there will be no emergency care – in part this fear is based on how poorly the burn was handled. She also experiences flashbacks to the suicide of a male friend at age 16. She says when she looks at me she sees the face of the woman prisoner who set herself on fire and burned to death. She does not remember the crime that landed her in prison. She has never been in SHU, nor to observation. She believes that officers treat women with mental illness terribly, calling them stupid and crazy. OMH did offer group meetings after the prisoner burned herself to death. She is concerned it is hard to get medical attention in DOCS. She has been in Keeplock. She has an eight year old son who is being raised by her father in Syracuse. She does not feel her medical care is adequate. Her clinical chart reflects Mental Health Level 4, she was at CNYPC on 6/10/03, and a note states the PTSD symptoms are diminished, but she still suffers nightmares. She is diagnosed PTSD on 5/16/03. She has been prescribed Neurontin. Her clinical chart corroborates her history, and there are notes about trauma and anxiety. A 6/10/03 note summarizes flashbacks, nightmares, anxiety, etc., secondary to PTSD. She has been in and out of outpatient treatment while incarcerated.

Example of:

PTSD in GP, outpatient treatment

Witnessed other prisoner burn self to death

Worsening of PTSD, related to lack of adequate medical care

R.B.

(Interviewed while housed in SHU).

R.B. has been in prison for two years. She has been in SHU for one week. She has discontinued mental health care. She feels the restrictions in SHU are degrading and excessive. She did 30 days in SHU at Bedford. She gets depressed in SHU. Some of her term has been Keeplock, once for being out of place at work. When male officers walk by her SHU cell at night it scares her. She can't sleep. She isolates herself, does not talk to anyone, she just reads. She reports that a lot of women in SHU are very depressed. She was in treatment for depression, she thinks she was taking Paxil, but they would not tell her what medication she was on so she stopped taking it. It helped her control her temper. She has a lot of trouble controlling her temper in SHU. For example, yesterday they searched her cell while having her locked in the shower. She has not been in observation. She took Ritalin when she was in a group home growing up, and the judge recommended that she receive mental health treatment, but she has seen mental health staff only three times in the last nine months. She has a drug problem and wants to do ASAT. She says that her mother does not know where she is. Her chart reflects no mental health notes at Albion. Diagnoses are not filled out on screening forms, she is assigned Mental Health Level 6, and it is noted she does not seem to want mental health services.

Example of:

Depression in SHU

Court recommended mental health treatment, not provided
Drug treatment not provided
Worse depression in SHU
Temper worse in SHU

Auburn Correctional Institute – 10/29/03-10/30/03

D.D.T. (Interviewed while housed in observation).

D.D.T. was transferred to observation on 7/31/03 (three months in Observation, if his history is accurate) from the SHU at Cayuga. He had been in prison since Jan., 2003. He says he is in observation "for personal issues." Mental Health staff at Cayuga put him on a 1-to-1 watch after he told them how he was feeling. When they took him off the watch, he tried to hang up. He tells me "I wanted to do it (die), I'll leave it at that." He had one prior suicide attempt. He is depressed but does not take any psychiatric medications. He thinks his depression is worse in SHU. He can't brush his teeth, can't shower, has nothing to do, this forces him to think more painful thoughts about his family, and he becomes even more depressed. He was in SHU, his first stint, for refusing to double-bunk at Five Points. "It's hard to be in a cell with someone you don't know, lots of dudes don't know how to communicate, and that leads to more problems." He hears voices telling him to kill himself, and that's what leads him to attempt suicide. The voices occurred for the first time while he was in the SHU at Cayuga. They continue to command him to harm himself in observation. He has not taken psychiatric medications in prison, has not been at CNYPC. On mental status exam, this man is obviously depressed, tells of hearing voices and exhibits internal preoccupation consistent with hallucinations. He is coherent, there is some anger and agitation but mostly psychomotor retardation, and a pervasive sense of hopelessness. In observation he talks to Ken daily, mostly at cell-front but sometimes for a few minutes in an office. He has a drug history and was in drug treatment in the community, but has not had drug treatment in prison. He has a daughter and her mother brings her to visit. He is clear that his suicidal behavior is related to being in SHU, but he has little psychological insight, or rather he is not open to sharing what is going on in his head and his emotional life. He has a lot of trouble sleeping, in SHU and in observation. He says that they are not treating him, so he would rather return to Cayuga SHU where, at least, he has earphones and recreation – here, he gets no treatment, until today when they gave him paper slippers he was without clothes, and he has nothing to do but pace. In his clinical chart there are notes at Auburn reflecting the staff's impression his emotional complaints are not authentic, and it seems from the notes that staff are keeping him in observation to punish him or educate him about "feigning." This man seems credibly depressed with command hallucinations and likely other psychotic features. His mental illness is clearly worsened by the SHU. His clinical chart reflects that OMH staff at Auburn believe he is malingering command hallucinations and is not suicidal, but really wants to avoid double-celling. They conclude no Diagnosis or ASPD. If this man does not suffer from mental illness, why is he being retained in observation for months? It seems likely his

true symptomatology lies somewhere between what Dr. Langbert thinks, i.e. no diagnosis, and what the prisoner says, i.e. depression with command hallucinations telling him to harm himself. He is both manipulative and depressed.

Example of:

SMI (Depression, R/O psychosis) in SHU in Medium

Transfer to observation at Auburn

Remain in observation long time

OMH doubts there is SMI

Continue to hold him in observation without amenities – punishment?

L. Z. . (Interviewed while housed in observation).

L. Z. has been in prison for 22 years, and this is his second admission to observation. He was admitted to CNYPC for six months approximately two years ago. His OMH case was closed last Sept. per his request. He went to CNYPC because he "broke down" – he "shut down," stayed in his bunk, forgot to eat, "went off," and tried to hurt himself. Now, he feels suicidal again, his mind is confused, hasn't eaten in 13 days, says he does not want to talk and wants to return to GP. His crimes involved bad checks. He says this is not a depressed episode – he's been depressed – rather this is a "total shutdown." He hasn't done much SHU time, but he was admitted to CNYPC from the Box. He does not keep track of time, and says he gets paranoid. This is his third major breakdown. On mental status exam this man has tattoos and scars from cutting on his forearms, he is depressed and somewhat confused with psychomotor retardation. He has no drug or alcohol history, and has worked in electrical. He does not think he is crazy. He was on Thorazine, 900 mg. per day, at one time. He says Prozac is not helpful. His clinical chart reflects a 5/29/02 (second) admission to CNYPC, and transfer on 8/21/03 from Elmira to Auburn. Dr. Wilson did a 32 page psychological assessment, pointing to "malingered depression" and ASPD/psychopath, with recommendation that further admissions to CNYPC would not be effective. He was placed on an outpatient Behavior Management Plan on 5/22/02, for arm cutting, pulling his toe nails, head banging, biting himself, burning himself with cigarettes, and hanging up. Medications include Zyprexa 5 mg. hs and Zoloft 200 mg. His diagnosis at discharge from CNYPC was Adjustment Disorder with Depressed Mood. This man seems to be suffering from a Major Depressive Disorder, this being his third episode (at least), so it is recurrent. He needs a higher level of care than is possible in the satellite unit. He should be transferred to CNYPC for evaluation and medication assessment, and then he may need ICP placement for a period of time. Of course, in his Behavior Management Plan, it is stated that he would not benefit from ICP and should not be re-admitted to CNYPC. Subsequent notes reflect diagnosis Anxiety Disorder, admission to and discharge from OMH caseload, report of "many problems."

Example of:

SMI (Depression, R/O psychosis) in observation from GP

Needs hospital, but Behavior Management Plan says no re-admit to CNYPC

Un-diagnosis by Dr. Wilson at CNYPC
Behavior Management Plan
Continued on medications in spite of un-diagnosis
Inadequate treatment

C.E. (Interviewed while housed in SHU).

C.E. has been in prison since 2000 and has 22 months more to serve. He says he has a new "outside case" for using a weapon – a razor that he used to try to kill himself. (He shows me many cuts and scars on his forearms and legs). He has been cutting himself since childhood. He also has had "imaginary" or "invisible friends" since childhood. He used marijuana on the streets, no other drugs. He has been hearing voices. He explains that since he was seven or eight years he has been talking to things that can't talk back – he believes they can talk back – and then they do. Now the voices have long conversations with each other in his cell, sometimes it sounds like someone he knows. It was in Jan., 2003, when he was in GP, that he broke a used razor to cut himself. They said it was contraband, and they alleged that he threatened the psychiatrist with the razor – which he denies. He had been on Haldol decanoate when he came to Auburn, and here they switched him to his current medication, Seroquel 600 mg. er day. He has been to CNYPC twice for cutting. He has been on medications for his command hallucinations throughout his prison term. He has been to observation quite a few times, in various institutions. One time it was because he was slamming his penis in a locker door in response to command hallucinations. The only reason he doesn't get picked on by COs like others with mental illness is that he stays out of their way. He has not been in ICP. He was referred to ICP at Elmira but he was denied, he says because "they want a more calm person." Voices tell him to hang up and to cut. He did hear voices telling him to attack a psych, but he did not act on the command, however he does feel the psych is out to get him. He admits he gets paranoid. He describes the strip cell that is observation at Elmira, talks about staff opening windows in Winter to freeze the naked occupants, and admits to smearing feces once in response to command hallucinations. Being in SHU makes him feel like cutting. Also, he cannot read in SHU because he "can't keep my thoughts in the book." He goes off on a tangent about a Devil-worshipping cult, how the Devil came to him, how his voices are the Devil's, etc. – and as he explains all this his associations become more loose and his logic more impaired. On mental status exam, this man gives credible history of hallucinations; he exhibits flat affect, ideas of reference and problems abstracting. He seems somewhat bizarre and self-destructive. His logic is not rational. His thoughts are tangential, associations loose. His clinical chart is consistent with the history he presents. Medications in June, 2001, include Paxil 40 mg., Depakote 1,500 mg., and Zyprexa 10 mg. There have been many suicidal crises. Officers were concerned about him in 4/02 because he threatened "to pull his testicle out." This man suffers from a severe and persistent mental illness, most likely Schizoaffective Disorder or Bipolar Disorder with Psychotic Features. He does better on the Seroquel 600 mg. is prescribed, along with antidepressants and mood stabilizer, but conditions in SHU exacerbate his mental illness and tendency to cut himself and hang up in response to command hallucinations (which the medication does not entirely control.

When admitted to CNYPC for two days ending 5/10/02 for cutting arms and smearing feces in the cuts, he was given the diagnosis of Impulse Control Disorder with Borderline Personality Disorder, even though he was prescribed Tegretol; but on 5/20/02 on an Admission Screening Form and on 6/19/02 on a "Face Sheet," he is given diagnosis Schizoaffective Disorder, Bipolar Type with Borderline Personality Disorder. Then, on 6/14/02, during second admission to CNYPC, Dr. John Wilson does a psychological assessment and writes an "Outpatient Behavior Management Plan." He diagnoses include no Axis I mental illness except substance abuse and Attention Deficit Disorder, but on Axis II he diagnoses psychopathy and other personality disorders. The Behavior Management Plan recommends no further CNYPC admissions, no ICP, return to DOCS with outpatient mental health treatment including current anti-psychotic and mood stabilizing medications. The chart I reviewed goes through 6/17/02, at which time the plan was to discharge him to GP, and his acting out and smearing feces was still being managed with "as needed" doses of anti-psychotic medications. This prisoner is seen often by OMH, but remains in SHU, where he repeatedly threatens or carries out self-harm, often in response to command hallucinations. He needs to be removed from SHU and transferred to a residential therapeutic setting – CNYPC or ICP. If there is an "outside case" secondary to contraband weapon as part of suicide attempt secondary to command hallucinations, OMH should step in and prevent further prison time for what would obviously be a suicide attempt driven by SMI.

Example of:

SMI (Schizoaffective Disorder or Depression w Psychosis) in SHU

Tickets for self-harm in response to command hallucinations

Outside court case secondary to self-harm (contraband)

Un-diagnosed, subsequently re-diagnosed during crisis

Then un-diagnosed by Dr. Wilson at CNYPC and put on Behav. Mgmt. Plan

Deterioration in SHU

X.C.

.. (Interviewed while housed in SHU).

X.C. has been in prison three and a half years doing his second bit, and he is due for release in 2009. He has been in SHU since July, 2001. He was doing well in Wende GP but received a ticket for a fight with another prisoner that led to 30 days Keeplock. Once he was in seg, he proceeded to accumulate other tickets, which brought him to SHU, first at Southport. By now he has received seven tickets while in Keeplock or SHU, and has a nine year SHU term. Currently he is on the loaf and staff are denying him showers. He had a history of anxiety and panic disorder prior to incarceration. He was also in Special Education because of emotional problems. He was raised by a good family. He has not been admitted to CNYPC, but he has been in observation 30 or 40 times. When asked why he goes to observation so often, he responds "they take me off my medicines, I take a rope and try to hang up, they put me in a strip cell for a few days, then they start giving me my medicine again." He was prescribed Xanax in the community, but correctional physicians refuse to give him that, so he was on Seroquel and is now prescribed Remeron. When he is transferred from one institution to another,

they usually stop his medications, and the doctor at the new place starts something else. He hears voices when he experiences panic episodes. He has been hearing voices a lot in the last few months (one wonders if this is a result of his being in SHU and having his anti-psychotic medication, Seroquel, discontinued). He hears the voices of friends cheering him on (command hallucinations) to do violence. He also gets very depressed. He has asthma, and when he is put behind glass (Lexsan), he panics because he fears he won't be able to breathe nor to summon help when he needs it. In the last month his anxiety has mounted and he has been hearing the voices more. Meanwhile, he keeps getting tickets, they've put him on the loaf – he's afraid he's given up. The depression is worse. "SHU makes you have a short temper, there's more anxiety, you become a different person, at times I feel like I'm going crazy. Mental health staff have given input in his disciplinary hearings. He tries to read to stay calm, but while he was a good reader, he has a lot of trouble concentrating when he's in SHU and then he cannot remember what he's read. He says he does not see eye-to-eye with Dr. Lambert, the prescribing psychiatrist. He was taken off his medications until a month ago. He says he is behind glass because he flooded his toilet – he tells me it was stopped up and he didn't do anything to it. He gets very claustrophobic behind glass, and he believes that since he has Hepatitis C, he should not be on loaf for health reasons. He has not received Tier 3 tickets at Auburn, but was transferred here with a term behind glass still riding. On his clinical chart there are treatment plans for 6/3/03 and 7/15/03, but the chart reflects that staff think he may be malingering, and therefore they deny him treatment. This man clearly suffers from serious mental illness – a combination of anxiety/depression/and very severe reaction to isolated confinement that includes hallucinations and losing control of his temper and experiencing panic episodes. Staff treat him as if he is malingering, his diagnosis is substance abuse and ASPD, and thus they medicate him inadequately and he continues to deteriorate. He has cycled from SHU to observation and back many times for self-harm. Progress notes reflect many signs of anxiety/depression/agitation. Meds at various times include Klonopin, Paxil, Clonidine. There is no psychological assessment, and there is no paperwork from any CNYPC admissions in chart. A 10/28/02 "Treatment Plan Review" says he is mostly manipulative, should be subject to DOCS disciplinary procedures, and if he attempts self-harm he should be given emergency medical care only and returned to his cell (i.e., no more observation admissions). He cycles often between SHU and observation and back to SHU. He needs to be removed from SHU and transferred to a residential mental health treatment setting such as an ICP.

Example of:

Atypical SMI (Anxiety, panic, with psychosis and hallucinations) in SHU

Tickets accumulate in SHU, where he had few in GP

Deteriorates in SHU, gets suicidal

Very many admissions to observation – cycling from SHU to observation and back to SHU

Viewed as malingerer

Inadequately treated

E.E.B.

. (Interviewed while housed in SHU).

E.E.B. has been in prison since 1999 and will be released in seven months. He has been in and out of SHU since 2001. He was in the ICP from August to September, 2003, then a CO thought he was talking to him when he claims he was not, and he was kicked out of ICP and sent to SHU 9/30/03. He claims his mental health record did not play a part in the disciplinary hearing, even though he told the hearing officer about his mental illness. He has experienced auditory hallucinations since 2002. But his history of serious mental illness goes back much further in time. In school he had a lot of problems, and his teacher thought he was retarded. His mental illness was not treated in the community. He has been hearing auditory hallucinations for a year, or since he was in the Greenhaven SHU. He also has difficulty in GP because he is paranoid. He tells me that at Adirondack Corr. Facil. something awful happened in 2000, pictures were taken, and until today officers poke fun at him because of it. He is prescribed Seroquel 500 mg. per day, which he reports is better than Geodon. He has been in observation many times, mostly on account of suicide attempts. He thinks about suicide a lot, and wants to die. He doesn't believe he is human. He does not want to talk about the situations that haunt him. Officers disrespect him repeatedly, and he silently curses them. Since Adirondack, he doesn't actually say anything, but the COs tell other prisoners about the incident. His clinical chart contains an 8/27/03 chart progress note in the ICP, reporting a rape at Adirondack and fears about HIV status. He is reported to have had no mental illness history prior to the rape, but has been intermittently anxious and suicidal since it happened. Diagnoses in chart include Depressive Disorder w Psychotic Features, Delusional Disorder, Schizoaffective Disorder, or, upon admission to Observation at Auburn on 5/3/02, Depressive Disorder NOS. Meds include Paxil and Risperdal (2 mg. b.i.d.) Repeatedly admitted to observation for suicide risk. Spent a lot of time in SHU, e.g. at Marcy CF SHU 200 in August, 2001. He was admitted to CNYPC on 4/15/03. A 10/2/03 progress note by Dr. Langbart reflects: "This individual has failed to show up to receive medications. According to policy they will be discontinued." Dr. Langbart's notes reflect that this prisoner suffers delusions, by 10/7/03 he was in observation on account of paranoia and suicide plans, and Dr. Langbart discusses prescribing Geodon or Seroquel, yet he discontinues medications when the prisoner non-complies, and he supports discharge from ICP on account of a ticket the prisoner received while not taking the medications. When he was delusional and suicidal and admitted to observation on 10/7/03, he had been back in SHU for a short time. He was not seen by a therapist or Dr. Langbart over a weekend, and was discharged from

RCTP back to SHU on 10/15, even though it had been noted that he was experiencing a psychotic decompensation. There is discussion in the notes of his wish to return to ICP, but he could not because he had a 90-day SHU term to serve and he had assaulted an officer who is in ICP. In January, 2004, he is back in RCTP because he is paranoid and suicidal. He has been in SHU in the intervening time. Staff want to send him somewhere safe until he goes to CNYPC for discharge planning, but there is nowhere to send him. Notes consistently reflect paranoid delusions and other signs and symptoms of SMI. He is sent to GP, where he gets into trouble and becomes paranoid and needs re-admission to RCTP. Then he is assigned to Involuntary PC. On 3/17/04 he is re-admitted to RCTP again, having "survived" in IPC, but remaining delusional. His diagnosis throughout this period is Schizoaffective Disorder/Depressed, and he is given anti-psychotic medications. A 5/20/04 admission note to CNYPC inpatient reflects paranoid delusions and thought disorder, a diagnosis Paranoid Schizophrenia, and a recommendation that he be civilly committed to a psychiatric facility after release from prison. In summary, this man suffers from a serious mental illness, likely Paranoid Schizophrenia. Throughout his incarceration he is repeatedly in SHU for behaviors related to his mental illness, and time in SHU worsens his condition. He is prescribed anti-psychotic medications while staff also admit him to observation repeatedly, to ICP, etc. He is kicked out of ICP for alleged assault on an officer, and given 90 days in SHU. But he is delusional and taking anti-psychotic medications all along. Then, he is repeatedly sent back to SHU, the OMH staff, including Dr. Langbart, agree he needs ICP but cannot go back to ICP because of assault on staff, and finally he is sent to CNYPC for discharge (from prison) planning, is diagnosed Paranoid Schizophrenia, and civil commitment after release is recommended. If he is seriously mentally ill to the point of needing civil commitment, why was he repeatedly kept in SHU and permitted to cycle to observation? While there are notes along the way about his being manipulative, he was consistently diagnosed psychotic while in DOC. Dr. Langbart discontinued his medications at one point because he failed an appointment, but OMH did not intervene in disciplinary proceedings even though he was clearly delusional when he received tickets.

Example of:

SMI (Psychosis, likely Paranoid Schizophrenia) in SHU

Was kicked out of ICP for behavior

Tickets related to SMI, but OMH not active in process

Being recommended for civil commitment after release

P.T.

(Interviewed while housed in ICP).

P.T. has been in prison for six years. He has been in ICP for a year. He previously spent two years in SHU because of three tickets, all given while he was hearing voices. He began hearing voices on the street. He saw a psychiatrist in the community, but was not prescribed medications. He self-medicated with marijuana, which he reports calmed his nerves. When he entered prison, the voices became worse and began commanding him to kill himself. Risperdal was prescribed when he was incarcerated at Rikers Island. He is currently prescribed Haldol Decanoate, and

Cogentin. He has been assaulted while in a psychotic state, but he received a ticket and a year of SHU time anyway. He gets very paranoid in the Box, and loses control so that he receives more tickets. In ICP he does much better. He did have a relapse in May, 2003. He was admitted to CNYPC for two months because he was hearing voices, and they changed his medication from Risperdal, which caused a lot of side effects, to the Haldol he is currently taking. He had prior relapses (psychotic episodes) when he was in the Box, especially when he was taken off his medications. Prior to his admission to CNYPC, he had been taken off medications at ICP and consequently got into trouble with officers and received five tickets – the charges were dropped and he was sent to CNYPC. He did have breakdowns in SHU, and he spent a lot of time behind glass (Lexsan), he does not know why. In SHU, the loud noises bother him, especially in A Tank. He got agitated, he lost memory, he lost his mind, he got confused, his thoughts started going faster and faster. He does not think he would have had as many relapses if he had not been in SHU. His last ticket was in December, 2002. That's when he was granted a time-cut and transferred to ICP. He believes that if you get a Tier 3 ticket in ICP you get kicked out and cannot return. He was born in Guyana and came to the USA in 1989, but he faces deportation after he is released from prison. On mental status, he has flat affect, gives credible descriptions of command hallucinations and psychotic decompensation, he is concrete and there is a thought disorder.

This prisoner's thick chart corroborates his history. Notes consistently document recurring psychotic episodes, diagnosis is Schizophrenia, Paranoid Type, meds are Haldol or Risperdal; e intermittently fails to comply, was admitted for the first time to CNYPC from 9 to 11/01 and spent some time in 5-point restraint while hospitalized. He was admitted to CNYPC again from 6/5/03 through 8/6/03. He had multiple admissions to observation at the RCTP while in SHU. In summary, this man suffers from chronic severe mental illness, most likely Schizophrenia or a related condition. He is in ICP, which is an appropriate placement, and he is responding positively to medications and the treatment milieu. He was known to have a history of serious mental illness, and should never have been placed in SHU, where his condition deteriorated. His SMI was not given enough attention in the disciplinary process, and consequently he spent a lot of time in SHU where his condition worsened.

Example of:

SMI (Paranoid Schizophrenia) currently in ICP

Was in SHU, deteriorated in SHU

Cycles from SHU to observation and CNYPC and back to SHU

OMH is not sufficiently involved in the disciplinary process

L. U.

7. (Interviewed while housed in ICP).

L. U. has been in prison for one and a half years. He has been in ICP for one week. Previously he was in SHU at Attica for four months, and then for three months at Auburn. He received a time-cut, and is currently on Keeplock. He reports that COs teased him incessantly when he was in the Box. He tells us that on March 24 of this

year, as he was returning from a visit, a CO wanted to see the picture he was carrying. The CO hit him. Later, the same CO came to his cell and he threw an orange at him, had a meltdown, broke his t.v., the COs beat him, and he was given eight months in the SHU. He complains of panic attacks, worse in SHU, and he often awakes in a panic. He is prescribed Seroquel, Depacote and Dilantin. Prior to incarceration he went part way through college, but was admitted to psychiatric hospitals several times for a psychotic disorder. He reports he is diagnosed anxiety and depression by OMH, but he has a history of paranoia and being diagnosed Bipolar or Schizophrenic in the community. He has been prescribed Depacote for many years. In SHU, he learned to keep his mouth shut and not respond to taunts. He told a CO about being raped, and ever since he has been teased by CO's about it. He was behind glass (Lexsan) the whole time he was in the SHU at Attica. He thinks he is treated well at ICP, but he hasn't seen his counselor for a month. He was admitted to CNYPC twice, and has been in observation many times. He was in ICP at Attica prior to going to SHU. He didn't like Attica ICP as well as the one at Auburn because at Attica he had to mix with GP more. On mental status exam this man is restless, moving his legs constantly and grimacing, he has obvious facial tics, he is quite flat, bizarre, anxious and agitated. He cannot answer whether he hears voices. His clinical chart reflects diagnosis of Schizophrenia, Undifferentiated type on 4/19/02. He was prescribed Zoloft 100 mg., Zyprexa 20 mg., Depakote 1,500 mg., Haldol Decanoate 100 mg. q. 4 weeks, and Dilantin on 4/4/02. He has been admitted to CNYPC and discharged back to SHU. No clinician doubts his diagnosis, and he cycles from SHU to observation and CNYPC and back to SHU. In summary, this man suffers from longstanding chronic and severe Schizophrenia, with a history of treatment pre-incarceration and the prescription of anti-psychotic and mood-stabilizing medications as well as ICP treatment currently (for one week). His case illustrates the problem of officers teasing prisoners with SMI, the consignment of prisoners who should be in ICP to SHU for disciplinary reasons, and the problem of a prisoner with SMI telling officers too much (about a rape) and then being harassed as a result. He has only been in ICP for a week, so it is quite possible he will cycle again to SHU for behaviors driven by his mental illness.

Example of:

SMI (Schizophrenia) in ICP one week, was in SHU

Deteriorates in SHU

Cycles from SHU to observation & CNYPC & back to SHU

Teased by officers

G.U. (Interviewed while housed in the ICP).

G.U. has been in prison for four years on his fourth term. He is to be released in early 2004. He is confused, his memory is severely impaired, his affect is flat and there are absences during our interview where he stares blankly and cannot continue a coherent narrative. He does not remember his ID number. He has not been in SHU. He has been in observation, and is angry about being left in a strip cell, naked, for four days. He cannot tell me when this happened. He does not know what treatment he

receives. He knows he received SSI disability on psychiatric grounds prior to incarceration. This man is severely disturbed and incoherent, he is practically mute. His very thick clinical chart contains diagnoses of Schizophrenia, Undiff. Type, substance abuse and ASPD. Medications include Zyprexa and Vistaril. He also suffers from medical ailments, including hypertension. Commitment papers to CNYPC reflect that he sits for days refusing to talk (catatonia?). He is reported to be difficult to treat because he does not respond and does not comply, and he is very delusional. He was denied parole in Sept., 2002, because he refused to sign papers.

Example of:
SMI (Schizophrenia) in ICP
Very disturbed

E.D. . (Interviewed while housed in General Population).

E.D. has been in prison since the age of 24. His psychiatric medications were stopped when he came to Auburn. He hears voices all the time, including during our interview. He arrived at Auburn from CNYPC. He witnessed a fight, became scared, refuses to come out of his cell, and is not eating. He rarely goes to recreation. He talks to the voices he hears in his head. He intermittently feels suicidal. The other prisoners know he is mentally ill, but he does not seek mental health treatment. He has been admitted to CNYPC once, and did not like it because "there are too many crazy people." He has been in observation several times. He was in a strip cell in A Tank for a month when he first came to Auburn, he had no mattress and no clothes. Mental health staff came to see him occasionally, took him to a room once. He reports many depressive symptoms, including voices. The voices are multiple, one being the Devil, and some command him to hurt himself. When he is in a cell by himself he gets increasingly anxious and depressed, the voices become more intense and self-castigating. He was in ICP once. He has a history of psychiatric hospitalizations pre-dating incarceration, going back to age nine or ten when he was at Bronx State Hospital for years. He was in Special Education at school. His family does visit. On mental status this man is internally preoccupied, displays strong First Rank Symptoms including thought insertion and the belief that OMH staff read his mind. He elaborates delusionally about the doctors sucking his thoughts out of his mind with a magnetic force instrument. There is flat affect, memory deficiencies. His clinical chart reflects discontinuation of psych meds in 12/02. He was diagnosed Bipolar Disorder and Impulse Control Problem along with ASPD. He made multiple suicide attempts, some serious but some gestures. But then he was admitted to CNYPC on 11/12/02 from Sing Sing, where he was suspected of malingering. His medications included Depacote, Remeron, and at other times, Risperdal, Trazadone and Celexa. A long report of psychological assessment by Dr. John Wilson concluded that he has low intellectual functioning but no Axis I pathology, he scores high on Hare's psychopathy checklist, and he malingers - yet he is kept in a strip cell for a month. Dr. Wilson includes in his assessment the recommendation that antipsychotic and mood-stabilizing medications may be helpful, but this should not be taken to mean he suffers from a serious mental illness. He has been in SHU and ICP but

is currently in GP. In summary, this very disturbed man is actively hallucinating, but he has been denied adequate mental health care after returning from CNYPC, where he was assessed as not suffering from SMI and put on a behavior management plan.

Example of:

SMI (Active psychosis, likely Schizophrenia or Schizoaffective) in GP

Has been in SHU, deteriorates in SHU

Describes harsh conditions in A Tank

Un-diagnosis at CNYPC

Continued on psychiatric medications

Inadequate treatment for active psychosis

D.O. (Interviewed while housed in General Population).

D.O. has been in prison since 1996. He is not in mental health treatment, but believes he can get it if he asks for it. He is a loner. He experiences absences and memory problems. He calls them black-outs. He was admitted to CNYPC in the early 1990's, transferred from jail. They diagnosed Black-Outs, Depression and Multiple Personality Disorder. An alter-ego (possible multiple personality?) is named James. He spent three months in the Box in 1996. Mental health staff have told him there's nothing they can do for him – he used to put in slips requesting help, but he has given up. He is not permitted to see the psychiatrist. He is told he has been in fights, but he does not remember the fights. Or, things are moved and he doesn't recall when or how that happened. He once took Prozac, but that didn't help. He has other (imaginary) people – "Timmy," "Johnny Kool" – who come around and talk to him. On mental status this man is confused and a little bizarre. His thin clinical chart contains diagnosis Multiple Personality Disorder. Around 1993 he spent 22 months at CNYPC, with a diagnosis Multiple Personality Disorder, and Rx Prozac.

Example of:

Mental Illness in GP

Mental Illness (Dissociation, possible Multiple Personality Disorder) does not fit categories for which treatment is offered in DOCS/OMH, so he goes without treatment

Need to rule out psychosis

F.W. (Interviewed while housed in SHU).

F.W. has been in prison for 12 years on his second bit, and is serving a 40-to-life prison sentence. He has been in SHU since 2002, and is currently behind Lexsan. He entered SHU with a nine month term, but attempted suicide in SHU and as a result was given a ticket which resulted in an additional eight month term. In September he was in observation and was admitted to CNYPC, and then returned to Auburn SHU (he had been at Great Meadow). He says he has been in observation since July (three months) at one institution or another. He was in A Tank, stripped naked. His problem is

he cuts his wrists in suicide attempts. He was also on a hunger strike. He has made other suicide attempts. He was given forced intramuscular medications at CNYPC. He does not take any medications at Auburn, but he is sent to observation. He has asked for medications several times, but they have refused his requests. The hearing officer who added eight months to his sentence did talk to mental health. He has no pre-incarceration psychiatric history, and only the one admission to CNYPC. He did try to kill himself by hanging in the county jail. Being in SHU makes him feel like he is suffocating, he gets very anxious, he experiences panic attacks, he gets paranoid, he gets up two or three times in the middle of the night afraid someone is attacking him, and he is unable to concentrate and cannot read the Bible as he usually does – he says he never had feelings like these prior to being in SHU. This is his first time in SHU, and he had no SHU and no trips to observation between 1991 and 2002. He reports he has been kept naked for long periods as he was transferred from the MHU (observation) to A Tank and then to the Hospital, but the worst was the MHU. On mental status examination, there are scars on both wrists from suicide attempts months ago, and he speaks in halting English, exhibits depressed affect, anxiety, some agitation, and psychomotor retardation. His clinical chart reflects no psychiatric history prior to incarceration, but several suicide attempts while in prison. He did well in prison, getting his GED and holding various jobs in honor block, until he received a tier 3 ticket in 2002 for assault that sent him to SHU. He had been diagnosed Bipolar for a while, and was prescribed various medications, including Risperdal. He was admitted to CNYPC for the first time on 8/25/03, was noted depressed and suicidal, was prescribed Benadryl and Remeron (15 mg./day). He tends to be under-diagnosed, as Adjustment Disorder with Disturbance Of Conduct, but on 8/22/03 he was diagnosed Major Depressive Disorder, single episode. On 8/25/03 he was transferred from RCTP at GMCF to CNYPC with this note: "Admitted to the unit on 8/19, from Upstate CF after his returning there, been in the unit twice in past two weeks. Last night was making suicidal gestures, put a sheet around his neck. Hopeless, and helpless. Decrease in his appetite, wants to die. Very labile. Between tears and laughter, rocking. Not sleeping at all." Upon discharge from CNYPC on 9/18/03, he was given "no diagnosis" on Axis I, after a psychological evaluation By Edwin Debroize found no diagnosis on Axis I and high Hare psychopathy score. He has been repeatedly suicidal since being in SHU, and was in observation for at least two months in Sept. and Oct., 2003. This man clearly suffers from severe depression, made worse by SHU. His treatment needs are not adequately addressed subsequent to a psychological evaluation at CNYPC where they opined no diagnosis on Axis I. He needs to be in a setting providing more mental health treatment, e.g. ICP.

Example of:

SMI (Depression with Psychosis, R/O Bipolar) in SHU

Deteriorates in SHU

More tickets in SHU secondary to suicide attempts

Hearing officer considered mental health issues

Cycles from SHU to observation and CNYPC and back to SHU

Un-diagnosis at CNYPC

Continued on medications

G.G.N

8. (Interviewed while housed in SHU).

G.G.N has been in prison for 11 years on a 25-to-life term. He has been in SHU or long-term Keeplock for seven or eight years. He came to Auburn eight days ago, and has been trying to get mental health treatment. He is on the OMH caseload, but has never been admitted to CNYPC, and had no psychiatric history on the street. He is not taking psychiatric medications. He has never been to observation, but three days ago he tried to hang up – nobody knows about it. He hears voices commanding him to hurt himself or someone else. He was taking psychiatric medications until three or four months ago. He has been asking to see a psychiatrist to get medications, but he is told by mental health staff he doesn't need them. He used to take Elavil, Paxil and Haldol – the Haldol helped with the voices. The voices have been with him since 1995. He has trouble sleeping in SHU, and he is depressed a lot. He thinks OMH diagnoses him Paranoid Schizophrenia. He does not tell hearing officers about his mental health problems. He was in a stabbing incident in 2000 that led to a 15 month SHU sentence, but he was acting in response to command hallucinations at the time. He has never been in ICP but would like to be. The isolation of SHU makes his psychiatric symptoms worse, but he prefers SHU to population because he is afraid of others in GP. On mental status examination he speaks credibly of command hallucinations that get worse when he is paranoid, he hears the voices of an uncle who molested him when he was a child. His clinical chart contains a mental health screening, with diagnosis Adjustment Disorder and Anxiety. Many notes say there is no mental illness, and list no symptoms. He periodically goes to observation briefly. He asks to have medications re-instated, but his request is denied and he is returned to SHU, where OMH staff say he has no symptoms. But in 12/03, he is started on Zyprexa at Southport, and by 4/26/04, he is prescribed Zyprexa 20 mg. per day, Vistaril 50 mg., and Remeron 15 mg. per day, for a Diagnosis of Adjustment Disorder with Anxiety – and I found no notes to explain why he is on anti-psychotic and antidepressant medications. In summary, this man suffers from serious mental illness, is not being treated adequately and is in SHU. He reports that command hallucinations led him to the violent acts that resulted in his SHU term. OMH notes reflect no psychiatric problems, but then he is prescribed anti-psychotic and antidepressant meds. His chart makes no sense. He needs a relatively secure residential treatment setting such as ICP.

Example of:

SMI (Depression and Psychosis) in SHU

Deterioration of mental health in SHU

Un-diagnosis or lack of diagnosis by OMH

But then he is prescribed anti-psychotic and antidepressant medications

Tickets seem related to mental illness

B.R. . (Interviewed while housed in SHU).

B.R. has been in prison for over 16 years. He is in SHU, and has been in SHU for 30 days. His total SHU time is three or four years. He believes he was set up by COs, who planted a weapon in his cell. He has scars on his face from knife fights, mostly at Rikers. He says he has no psychiatric problems, is not in mental health treatment and is not taking psych meds. In SHU, he feels very frustrated and feels that the COs hassle the prisoners, for example by saying he can't have earphones when he should be permitted earphones. If he "gets into it" with the CO, his anger mounts and he gets in trouble. Surviving in SHU depends on who your neighbors are. If they make noise, you have trouble concentrating. He feels the COs in this SHU do not treat the prisoners with compassion. They do "banging therapy": if they don't like you, they put you next to a prisoner with serious mental illness who bangs and makes noise all the time. In A Tank, the COs control the toilets, keep the lights on all the time, and generally harass the prisoners. "They press your buttons."

Example of:

Denies mental health problem, in SHU

Complains of harsh treatment in A Tank

T.Y. . (Interviewed while housed in SHU).

T.Y. had been in SHU since 10/8/03, and is now behind Lexsan. He was given two years, and has outside charges. He takes Prozac, Atarax and a sleeping medication. He can't breathe in SHU because he has asthma. He has received a ticket for not being ready in time to go to sick call. He has been admitted to CNYPC, and has been in the Five Points STP for nine months. He requested a transfer out of STP, so they put him back in SHU. He wanted to go to ICP. He thinks his problems result from the COs harassing him in retaliation for what they think was his participation in the riot of 1991. He reports being beaten by COs on June 14. He has had about 30 tickets in SHU, compared to only a few in GP. He has been in and out of prison. He does not receive psychiatric treatment on the outside. He stays in his cell all the time because he is afraid of a possible attack by COs. He believes most of his tickets were due to being set up by COs. On mental status, he is anxious, wide-eyed, with pressured rapid speech.

Example of:

Possible SMI (Depression? – unclear, chart not reviewed) in SHU

Went to STP and back to SHU

E

RECYCLED
JED

APPENDIX E

Suicide Statistics from 1995-2004

1995 - total of 11 suicides. 4 of these (V.F. , G.G.S, G.G.T., N.N.J.) occurred in isolated confinement housing areas (36%). N.N.J. may have been in the RCTP dorm rather than in observation. We do not know the locations of 2 (N.N.K, M.M.S.).

1996 - total of 13 suicides. 6 of these (B.X. , D.D.H., Q.K. , H.H.H, H.H.I, H.H.R.) occurred in isolated confinement housing areas (46%). We do not know the location of 1 (N.N.L.).
U.U. committed suicide in the dormitory area of the MHU. U.U. was in the RCTP from the SHU at the time of the suicide.

1997 - total of 14 suicides. 3 of these (C.I. , A.A.B, E.B.) occurred in isolated confinement housing areas (21%).

1998 - total of 14 suicides. 10 of these (L.D. , M.K., I.F. , S.U. , Q.X. , U.G.,
M.P. , P.D. , M.M.U, J.S.) occurred in isolated confinement housing areas (71%).
C.C.J. was in the D housing unit at Downstate which is an area for psychiatric cases. The patients are not always on observation status. C.C.J. was not on observation status.

1999 - total of 8 suicides. 3 of these (I.Y., C.D., J.M.) occurred in isolated confinement housing areas (37%). In addition, M.E. was in isolation in the infirmary; H.H.D. was out to court at Rikers Island from Southport (he was a SHU prisoner at the time of the suicide);
N.X. was housed in E building at Downstate although it does not appear that he was on keeplock status (E building is described as disciplinary keeplock and when necessary, overflow of mental health inmates who normally would be housed in D building).

2000 - total of 17 suicides. 9 of these (K.O. , N.N.M, C.C.T. , Q.F. , G.H. , N.N.N., E.E.H.,
I.Q. , A.A.Q.) occurred in isolated confinement housing areas (53%).

2001 - total of 7 suicides. 4 of these (R.W. , A.S. , V.G. , T.E.) occurred in isolated confinement housing areas (57%).

2002 - total of 14 suicides. 5 of these (H.F. , Y.K. , Y.L. , P.R., S.D.) occurred in isolated confinement housing areas (36%). We do not know the locations of 4 of these suicides (A.A., H.H.F., C.M. , Y.T.).

2003 - total of 15 suicides. 6 of these (H.H.Z., B.B.A, P.N., I.I.A, I.I.B, G.A.) occurred in isolated confinement housing areas (40%). *I do not know where the information about B.B.A. was obtained. The SCOC report indicates GP without mentioning Keeplock. We need to verify Keeplock status of B.B.A.. We do not know the locations of 3 of these suicides (I.I.C, Q.F. , I.I.D.).

2004 - as of 11/17/2004 we know of 5 suicides and know that at least 2 of the 5 occurred in

isolated confinement housing areas (40%).

Year	Total Known Suicides	Suicides Known to be in Isolated Confinement	Percent Known to be in Isolated Confinement
1995	11	4	36%
1996	13	6	46%
1997	14	3	21%
1998	14	10	71%
1999	8	3	37%
2000	17	9	53%
2001	7	4	57%
2002	14	5	36%
2003	15	6	40%
2004 (incomplete)	5	2	40%
TOTAL	118	52	44%

F



APPENDIX F

Summary Tables of the 98 Inmates who are Included in Both the 2002 and 2004 SHU Studies*

Inmates whose Diagnosis was Changed from Axis I to Axis II

	Name	DIN	Diagnosis 2002	Diagnosis 2004	OMH Level 2002	OMH Level 2004	SPMI 2002?	SPMI 2004?
1.	List of 9 Inmates		296.7 - Bipolar I Disorder, most recent episode unspecified	301.83 - Borderline Personality Disorder	2	1	No	No
2.			296.34 - Major depressive Disorder, recurrent	301.7 - Antisocial Personality Disorder	1	1	No	No
3.			296.2 - Major depressive Disorder, single episode	301.7 - Antisocial Personality Disorder	1	1	Yes	Yes
4.			309.3 - Adjustment Disorder with disturbance of conduct	301.7 - Antisocial Personality Disorder	1	4	No	No
5.			298.9 - Psychotic Disorder NOS	301.9 - Personality Disorder NOS	1	3	No	No
6.			295.3 - Schizophrenia, paranoid type7	301.7 - Antisocial Personality Disorder	2	3	No	No
7.			298.9 - Psychotic Disorder NOS	301.7 - Antisocial Personality Disorder	1	1	Yes	No
8.			295.7 - Schizoaffective Disorder	301.7 - Antisocial Personality Disorder	1	2	Yes	No
9.			296.9 - Mood Disorder NOS	301.7 - Antisocial	1	2	Yes	No

Name	DIN	Diagnosis 2002	Diagnosis 2004	OMH Level 2002	OMH Level 2004	SPMI 2002?	SPMI 2004?
			Personality Disorder				

Inmates whose Diagnosis was Changed from Axis I to No Diagnosis

Name	DIN	Diagnosis 2002	Diagnosis 2004	OMH Level 2002	OMH Level 2004	SPMI 2002?	SPMI 2004?
1.	List of 13 Inmates	309 - Adjustment Disorder with Depressed Mood	V71.09 - No Disorder or condition on Axis I or Axis II	3	6	No	No
2.		312.3 - Impulse-control Disorder NOS	n/a	1	3	No	No
3.		296.32 - Major depressive Disorder, recurrent	n/a	1	4	Yes	No
4.		309 - Adjustment Disorder with depressed mood	V71.09 - No Disorder or condition on Axis I or Axis II	1	4	No	No
5.		300 - Anxiety Disorder NOS	V71.09 - No Disorder or condition on Axis I or Axis II	3	6	No	No
6.		311 - Depressive Disorder NOS	V71.09 - No Disorder or condition on Axis I or Axis II	3	6	No	No
7.		297.1 - Delusional Disorder	n/a	1	2	Yes	No

	Name	DIN	Diagnosis 2002	Diagnosis 2004	OMH Level 2002	OMH Level 2004	SPMI 2002?	SPMI 2004?
8.			309.4 - Adjustment Disorder with mixed disturbance of emotions and conduct	V71.09 - No Disorder or condition on Axis I or Axis II	1	6	No	No
9.			293.83 - Mood Disorder due to general medical condition	V71.09 - No Disorder or condition on Axis I or Axis II	1	4	Yes	No
10.			309.24 - Adjustment Disorder with Anxiety	V71.09 - No Disorder or condition on Axis I or Axis II	6	6	No	No
11.			311 - Depressive Disorder NOS	n/a	2	1	No	No
12.			300.4 - Dysthymic Disorder	n/a	1	2	No	No
13.			296.3 - Major depressive Disorder, recurrent	V71.09 - No Disorder or condition on Axis I or Axis II	1	4	No	No

Inmates whose Diagnosis was Changed from Axis II to No Diagnosis

	Name	DIN	Diagnosis 2002	Diagnosis 2004	OMH Level 2002	OMH Level 2004	SPMI 2002?	SPMI 2004?
1.	List of 4 Inmates		301.7 - Antisocial Personality Disorder	V71.09 - No Disorder or condition on Axis I or Axis II	2	6	No	No

	Name	DIN	Diagnosis 2002	Diagnosis 2004	OMH Level 2002	OMH Level 2004	SPMI 2002?	SPMI 2004?
2.			301.7 - Antisocial Personality Disorder	V71.09 - No Disorder or condition on Axis I or Axis II	6	6	No	No
3.			301.9 - Personality Disorder NOS	V71.09 - No Disorder or condition on Axis I or Axis II	2	1	No	No
4.			301.7 - Antisocial Personality Disorder	V71.09 - No Disorder or condition on Axis I or Axis II	6	4	No	No

Inmates who Received a Diagnosis but were Classified as OMH Level 6 in Either 2002 or 2004

	Name	DIN	Diagnosis 2002	Diagnosis 2004	OMH Level 2002	OMH Level 2004	SPMI 2002?	SPMI 2004?	Classified as OMH Level 6 with Diagnosis During 2002 or 2004 SHU Study?
2002 SHU Study									
1.	List of 8 Inmates		297.1 - Delusional Disorder	297.1 - Delusional Disorder	6	1	No	Yes	2002
2.			301.7 - Antisocial Personality Disorder	V71.09 - No Disorder or condition on Axis I or Axis II	6	6	No	No	2002

	Name	DIN	Diagnosis 2002	Diagnosis 2004	OMH Level 2002	OMH Level 2004	SPMI 2002?	SPMI 2004?	Classified as OMH Level 6 with Diagnosis During 2002 or 2004 SHU Study?
3.			309.24 – Adjustment Disorder with Anxiety	V71.09 - No Disorder or condition on Axis I or Axis II	6	6	No	No	2002
4.			301.7 - Antisocial Personality Disorder	V71.09 – No Disorder or condition on Axis I or Axis II	6	4	No	No	2002
2004 SHU Study									
5.			n/a	300 – Anxiety Disorder NOS	4	6	No	No	2004
6.			305.9 – Substance Abuse	301.7 – Antisocial Personality Disorder	4	6	No	No	2004
7.			312.3 - Impulse-control Disorder NOS	312.3 - Impulse-control Disorder NOS	2	6	No	No	2004
8.			V71.09 - No Disorder or condition on Axis I or Axis II	R/O Anxiety Disorder	3	6	No	No	2004

Inmates whose MH Level Changed to 6 from Another Level

	Name	DIN	Diagnosis 2002	Diagnosis 2004	OMH Level 2002	OMH Level 2004	SPMI 2002?	SPMI 2004?
1.	List of 10 Inmates		309 – Adjustment Disorder with Depressed Mood	V71.09 - No Disorder or condition on Axis I or Axis II	3	6	No	No
2.			n/a	300 – Anxiety Disorder NOS	4	6	No	No
3.			300 – Anxiety Disorder NOS	V71.09 - No Disorder or condition on Axis I or Axis II	3	6	No	No
4.			301.7 - Antisocial Personality Disorder	V71.09 - No Disorder or condition on Axis I or Axis II	2	6	No	No
5.			311 - Depressive Disorder NOS	V71.09 - No Disorder or condition on Axis I or Axis II	3	6	No	No
6.			305.9 – Substance Abuse	301.7 – Antisocial Personality Disorder	4	6	No	No
7.			309.4 - Adjustment Disorder with mixed disturbance of emotions and conduct	V71.09 - No Disorder or condition on Axis I or Axis II	1	6	No	No
8.			n/a	V71.09 - No Disorder or condition on Axis I or Axis II	3	6	No	No
9.			312.3 - Impulse-control	312.3 - Impulse-	2	6	No	No

	Name	DIN	Diagnosis 2002	Diagnosis 2004	OMH Level 2002	OMH Level 2004	SPMI 2002?	SPMI 2004?
10.			Disorder NOS V71.09 - No Disorder or condition on Axis I or Axis II	control Disorder NOS R/O Anxiety Disorder	3	6	No	No

Inmates whose MH Level Changed from 1 to Another Level

	Name	DIN	Diagnosis 2002	Diagnosis 2004	OMH Level 2002	OMH Level 2004	SPMI 2002?	SPMI 2004?
1.	List of 20 Inmates		298.9 - Psychotic Disorder NOS	298.9 - Psychotic Disorder NOS	1	2	Yes	Yes
2.			312.3 - Impulse-control Disorder NOS	n/a	1	3	No	No
3.			n/a	302.85 - Gender Identity Disorder	1	2	Yes	No
4.			296.32 - Major depressive Disorder, recurrent	n/a	1	4	Yes	No
5.			309.3 - Adjustment Disorder with disturbance of conduct	301.7 - Antisocial Personality Disorder	1	4	No	No
6.			309 - Adjustment Disorder with depressed mood	V71.09 - No Disorder or condition on Axis I or Axis II	1	4	No	No
7.			796.4	301.7 - Antisocial Personality Disorder	1	4	Yes	No

	Name	DIN	Diagnosis 2002	Diagnosis 2004	OMH Level 2002	OMH Level 2004	SPMI 2002?	SPMI 2004?
8.			312.3 - Impulse-control Disorder NOS	312.3 - Impulse-control Disorder NOS	1	3	Yes	No
9.			297.1 - Delusional Disorder	n/a	1	2	Yes	No
10.			298.9 - Psychotic Disorder NOS	301.9 - Personality Disorder NOS	1	3	No	No
11.			309.4 - Adjustment Disorder with mixed disturbance of emotions and conduct	V71.09 - No Disorder or condition on Axis I or Axis II	1	6	No	No
12.			293.83 - Mood Disorder due to general medical condition	V71.09 - No Disorder or condition on Axis I or Axis II	1	4	Yes	No
13.			301.7 - Antisocial Personality Disorder	301.7 - Antisocial Personality Disorder	1	3	No	No
14.			311 - Depressive Disorder NOS	311 - Depressive Disorder NOS	1	3	No	No
15.			298.9 - Psychotic Disorder NOS	298.9 - Psychotic Disorder NOS	1	2	No	No
16.			295.7 - Schizoaffective Disorder	295.7 - Schizoaffective Disorder	1	2	Yes	Yes
17.			300.4 - Dysthymic Disorder	n/a	1	2	No	No
18.			295.7 - Schizoaffective Disorder	301.7 - Antisocial Personality Disorder	1	2	Yes	No
19.			296.3 - Major depressive Disorder, recurrent	V71.09 - No Disorder or condition on Axis I or Axis II	1	4	No	No

	Name	DIN	Diagnosis 2002	Diagnosis 2004	OMH Level 2002	OMH Level 2004	SPMI 2002?	SPMI 2004?
20.			296.9 – Mood Disorder NOS	301.7 - Antisocial Personality Disorder	1	2	Yes	No

* Note: When analyzing the data concerning the inmates included in both the 2002 and 2004 SHU studies, we were unable to determine particular information for a few of the inmates due to the layout of the original SHU study spreadsheet. For this reason, these inmates were not included in certain counts; had they been included, there is a chance there would be a greater number of inmates who fall into the above-listed categories. The inmates who were not included in some of the comparisons are:

S E
W D.
B B R
C C D

G

10
10/10/2020

APPENDIX G

GLOSSARY OF ACRONYMS, PSYCHOTROPIC MEDICATIONS, AND INDIVIDUALS (WITH POSITIONS)

Glossary:

Assessment Program Preparation Unit (APPU): A unit at Clinton Correctional Facility that offers a “diagnostic and treatment program” to help victim-prone or fearful individuals be able to move back into the general population.

Academic Vocational Preparation (AVP): A program at Green Haven Correctional Facility comparable to the Intermediate Care Programs (ICPs) at other facilities.

Antisocial Personality Disorder (ASPD): A personality disorder listed in DSM-IV that features a pervasive pattern of disregard for, and violation of, the rights of others that begins in childhood and continues into adulthood. ASPD is not the same as Psychopathy (see below).

Atypical Antipsychotic Medication: The new generation of psychotropic medications that are prescribed for the treatment of psychosis (see list below).

Axis I Disorder: Part of a “multi-axial” format in DSM-IV that lists “Clinical Disorders and Other Conditions That May Be a Focus of Clinical Attention.”

Axis II Disorder: Part of a “multi-axial” format in DSM-IV that lists personality or character disorders and Mental Retardation, as distinct from Axis I Disorders.

Behavioral Health Unit (BHU): A planned expansion of OMH services designed to target prisoners with mental illness who have poor behavioral controls and a diminished capacity for emotional regulation which may be exacerbated by extensive isolated confinement. The purpose of the BHU is to assist these inmates in developing the necessary skills to assimilate back into the general inmate population.

Behavior Management Plan (BMP): Plan designed by CNYPC to treat inmates with mental illness and behavioral disorders.

Borderline Character Disorder: A diagnostic category listed under Axis II of DSM-IV, but this condition can include intermittent episodes of psychosis and severe disability.

“The Box”: Colloquial term for SHU

Case Management: A form of mental health treatment intervention, where a clinician follows a patient with serious mental illness over a long time period and manages the case, coordinating services rather than necessarily providing the actual treatment.

Cell Extraction: Forcible removal of a prisoner from a cell, most often conducted by a team of security staff in isolated confinement settings.

Central New York Psychiatric Center (CNYPC):

1) The forensic arm of OMH that provides and oversees both inpatient and outpatient services to prisoners in DOCS' correctional facilities.

2) The inpatient psychiatric hospital in Marcy, New York.

Command hallucinations: "Voices" that order the hallucinating individual to do something, such as attempt suicide.

Community Orientations and Re-Entry Program (CORP): A program at Sing Sing Correctional Facility that prepares prisoners for release and helps plan post-release arrangements in the community.

Decompensate: Generally, a psychiatric crisis or "breakdown"; more specifically, an acute exacerbation of a psychotic disorder.

Developmental Disability: A physical or mental condition that exists from childhood, including but not limited to Mental Retardation.

Department of Correctional Services (DOCS): The agency created by the State of New York for the purpose of operating prison facilities within New York.

The Diagnostic and Statistical Manual of Mental Disorders, 4th Edition (DSM-IV): A volume published by the American Psychiatric Association in 1994, wherein are listed the officially recognized diagnostic categories and criteria for their diagnosis.

Dual Diagnosis: Co-occurring mental illness and substance abuse.

Extrapyramidal Syndrome (EPS): A side effect of anti-psychotic and other medications, involving excess salivation and involuntary muscle spasms.

Ferguson Gown & Ferguson Blanket: A gown and blanket made of material that is difficult to tear, for use with a patient in observation for suicide risk.

First-rank Symptoms (FRS): A set of symptoms that are typically found in Schizophrenia and other psychotic disorders, reflecting problems distinguishing between inner and outer reality or between self and others. An example is "thought insertion," the symptom characterized by the belief someone is inserting thoughts into one's mind. Also known as Schneider's First-rank Symptoms, after Kurt Schneider, who first described the symptoms in Schizophrenic patients.

General Population (GP): A classification status and the name for the areas and programs of prisons where most of the prisoners are confined.

Global Assessment of Functioning (GAF): By convention, GAF is Axis V of the multi-axial system of diagnosis in DSM-IV. It is a scale of functioning from 0 to 100, where 100 denotes superior functioning and 1 denotes persistent danger of severely

hurting self or others or being incapable of caring for oneself. GAF scores below 60 denote moderate to severe psychiatric impairment.

Good Time: The time, usually measured in days, that are subtracted from an inmate's prison term for good behavior. A recommended denial of good time can be a disciplinary sanction.

Hare's Revised Psychopathy Checklist (PCL-R): A psychological assessment instrument utilized to determine the presence of psychopathy.

Ideas of Reference: Paranoid ideas.

Intermediate Care Program (ICP): DOCS programs that are jointly staffed by OMH and DOCS. Prisoners housed in ICP have been deemed unable to function in the general population due to the effects of a mental illness. ICPs are one form of a "step-down program."

Internal Preoccupation: An observed sign of body language, facial gestures and eye movements indicating that the patient being examined is paying attention to internal events such as hallucinated voices. The patient subjectively reports a "symptom" – the voices – but the clinician objectively observes the "sign" – internal preoccupation.

Involuntary Protective Custody (IVP): Confinement for an inmate who may be a potential victim or a witness likely to be intimidated, or who lacks the ability to live in the general facility community and who may for good cause be restricted from communication with the general inmate population, and who does not voluntarily accept admission into protective custody status.

Isolated Confinement: A designated area of a prison where prisoners are kept isolated from other prisoners, have minimal contact with staff, spend nearly 24 hours per day in their cells, participate in very few if any programs, eat alone in their cells and are mostly idle. Isolated confinement in NY DOCS includes SHU, Keeplock, Administrative Segregation and Protective Custody that involves lockdown.

Joint Commission on the Accreditation of Healthcare Organizations (JCAHO): A national accrediting agency for hospitals and healthcare organizations.

Keeplock: A disciplinary sanction that involves cell confinement (isolated confinement) for a specified length of time, which may be carried out in the prisoner's location or may involve transfer to a special cellblock or to SHU.

Loose Associations: A sign discovered during a mental status examination of a thought process involving ideas that are not connected to each other in a logical way, usually a sign of psychosis, typical of Schizophrenia.

Major Mental Illness: A loosely defined collection of diagnoses, including Schizophrenia, Bipolar Disorder and Major Depressive Disorder, that has been utilized to establish treatment priorities in correctional settings. It is distinct from Serious Mental

Illness (SMI), which considers functional capacity and includes a broader set of diagnoses.

Malingering: The feigning or exaggeration of symptoms for secondary gain.

Mental Health (Service) Level: A classification system utilized by OMH and DOCS to identify prisoners' need for services. Prisoners are assigned a level from 1 to 6 (there is no level 5), where 1 signifies a need for intensive mental health services and 6 signifies no need of treatment.

Mental Health Unit (MHU): Located in five maximum security facilities and seven medium security facilities, these units do not have any full time mental health or medical clinicians and require only a minimum of eight hours of psychiatric services per week. Southport and Upstate, all-SHU maximum security prisons, have Mental Health Units.

Mental Retardation: A disorder characterized by subaverage intellectual functioning with onset prior to age 18 and continuing deficits or impairments in adaptive functioning. It can co-exist with a serious mental illness, and is noted on Axis II of the multiaxial diagnostic formulation.

Mental Status Examination: The objective portion of a clinical assessment in psychiatry and related mental health fields.

Meryl Cooper Unit: A therapeutic community in the maximum security Clinton Annex. The program is designed primarily to help prisoners prepare for post-release life in the community.

Mood-stabilizer: a medication that limits the highs and lows of mood that accompany Bipolar Disorder and other Mood Disorders. The original medication in this group was Lithium, but a series of other medications have been found to be as effective (see list, below).

Neuropsychological (Neuropsych) Testing: Psychological assessment that focuses on the interplay between functional mental disorders and biologically based brain disorders, examining the relationship between behavior and brain functioning in the realms of cognitive, motor, sensory and emotional functioning. Includes intelligence testing and testing for organic brain disorders such as closed head trauma.

Not Otherwise Specified (NOS): A term that can be added to the end of a diagnosis, signifying that the diagnosis is relevant but criteria for firmly establishing a specific subcategory of the diagnosis have not been met. Thus, for example, Mood Disorder NOS signifies that the patient suffer from disordered mood but does not meet the criteria for a firm diagnosis of a specific condition such as Bipolar Disorder or Major Depressive Disorder; similarly Psychosis NOS signifies the presence of psychosis but insufficient evidence to specifically diagnose Schizophrenia or Delusional Disorder.

Observation Cells: Individual cells or rooms modified to safely house and provide close monitoring for agitated inmates or those at risk for suicidal behavior.

Office of Mental Health (OMH): The agency created by the State of New York for the purpose of controlling, providing and supervising the State's mental health services for New York State residents with mental illness, including mental health services for prisoners.

Protective Custody (PC): Confinement for an inmate who may be a potential victim or a witness likely to be intimidated, or who lacks the ability to live in the general facility community and who may for good cause be restricted from communication with the general inmate population, and who voluntarily accepts admission into protective custody status.

Posttraumatic Stress Disorder (PTSD): A diagnostic category that requires a history of a traumatic event and the continuing presence of a list of symptoms, which might include (but does not necessarily include) flashbacks, heightened startle reaction, constricted emotional range and so forth.

Psychomotor Retardation: A slowing of thinking and behavior, often a sign of depression.

Psychopathy: A diagnosis that is not included in DSM-IV, but is widely applied in forensic and correctional contexts. It overlaps the diagnostic category Antisocial Personality Disorder, and implies an especially intransigent callousness and lack of care about the feelings and rights of others.

Psychosocial Rehabilitation: See Psychiatric Rehabilitation.

Psychotropic medications: A category of medications with psychiatric effects – see list below.

Psychiatric Rehabilitation (or Psychosocial Rehabilitation or Social Rehabilitation): A variety of treatment interventions; including group therapy, vocational training, supported living in the community, day treatment, psycho-education, case management and other educational programs, aimed at helping the psychiatrically disabled individual participate fully in psychiatric treatment, remain stable, and enjoy the best quality of life possible, given the disability.

Reception: A facility within a correctional system where newly admitted prisoners spend a period of time at the beginning of a term being evaluated and assigned a security classification.

Residential Crisis Treatment Program (RCTP): Mental health observation cells and a dorm area where prisoners may be admitted and housed within the Satellite Mental Health Unit.

Re-traumatization: Repeat trauma in someone who had been traumatized earlier, for example the rape of an adult who had been sexually molested as a child constitutes re-traumatization.

Rule out (R/O): A phrase preceding a possible diagnosis, signifying that the diagnosis must be considered.

Satellite Mental Health Unit: Mental health treatment programs administered by OMH in most DOCS maximum security facilities. Southport and Upstate, both maximum security all-SHU prisons, do not have Satellite Units.

Schneider's First Rank Symptoms: (see First Rank Symptoms or FRS)

Serious Mental Illness (SMI): A substantial disorder of thought or mood which significantly impairs judgment, behavior, capacity to recognize reality, or ability to cope with the ordinary demands of life.

Serious and Persistent Mental Illness (SPMI): A term utilized by the federal government to guide states in establishing community mental health services. This category takes diagnosis and disability or level of functioning into consideration, and is superseded by and incorporated in the term Serious Mental Illness (SMI).

Social Rehabilitation: See Psychiatric Rehabilitation

Special Housing Unit (SHU): Twenty-three hour disciplinary isolated confinement unit in which prisoners are confined in small cells.

Special Needs Unit (SNU): Residential units with programming for inmates with developmental disabilities and/or mental retardation.

State Commission on Correction (SCOC): The state oversight agency which investigates and oversees correctional facilities.

Social Security Disability (SSI or SSA): A federal income supplement plan administered by the Social Security Administration which provides cash to meet the basic needs of aged, blind and disabled people with little or no income.

Specialized Treatment Program (STP): A program that provides assessment and treatment to seriously mentally ill inmates who, due to their disciplinary status, are housed in SHU.

"Step-down Program": A non-technical term for mental health programming that is a step down from the intensity of inpatient (hospital) treatment, but more intense than outpatient treatment.

Tangential thinking: An aspect of thought disorder where ideas are more tangential than linear.

Tardive dyskinesia: Involuntary movements due to brain damage secondary to taking older anti-psychotic medications for a long time

Thought Disorder: A term that evolves from the distinction in psychiatry between mental illnesses that involve abnormal thought processes (such as Schizophrenia and other psychotic conditions) and mental illnesses that involve abnormal affect.

Twelve Step Program: A leaderless group experience, modeled on Alcoholics Anonymous, where participants traverse twelve organized steps of self-healing in the process of becoming “clean and sober.” The term and the process have been generalized to other addictions.

Un-diagnosis: The process whereby the diagnosis of an individual who had been diagnosed with a serious mental illness is downgraded inappropriately to a less serious diagnosis or no diagnosis.

Word salad: a string of words that does not make sense, a sign that occurs in psychosis.

Psychotropic Medications:

(Listed by brand names, with generic name in parentheses)

Anti-psychotic:

Thorazine (Chlorpromazine)
Mellaril (Thioridazine)
Haldol (Haloperidol)
Prolixin (Prophenazine)
Serentil (Mesoridazine)
Stelazine (Trifluoperazine)
Trilafon (Perphenazine)
Navane (Thiothixene)
Loxitane (Loxapine)
Moban (Molindone)
Orap (Pimozide)

Atypical Antipsychotic:

Clozaril (Clozapine)
Geodon (Ziprasidone)
Zyprexa (Olanzapine)
Risperdal (Risperidone)
Seroquel (Quetiapine)
Abilify (Aripiprazole)

Mood Regulators/Mood Stabilizers

Lithobid, Lithonate, Eskalith (Lithium)
Depakote, Depakene, Depacon (Valproic Acid, Divalproex)
Tegretol (Carbamazepine)
Neurontin (Gabapentin)
Lamictal (Lamotrigine)
Trileptal (Oxcarbazepine)
Topamax (Topiramate)

Antidepressants

Effexor (Venlafaxine)
Remeron (Mirtazapine)
Serzone (Nefazodone)
Wellbutrin, Zyban (Bupropion)
Nardil (Phenelzine)
Parmate (Tranylcypromine)
Prozac (Fluoxetine)
Celexa (Citalopram)
Lexapro (Escitalopram)
Zoloft (Sertraline)
Luvox (Fluvoxamine)
Paxil (Paroxetine)

Anafranil (Clomipramine)
Desyrel (Trazadone)
Elavil, Endep (Amitriptyline)
Tofranil (Imipramine)
Sinequan, Adapin (Doxepin)
Vivactil (Protriptyline)
Norpramin (Desipramine)
Surmontil (Trimipramine)
Asendin (Amoxapine)

Anti-anxiety

Valium (Diazepam)
Librium (Chlordiazepoxide)
Klonopin (Clonazepam)
Xanax (Alprazolam)
Vistaril, Atarax (Hydroxyzine)
Tranxene (Clorazepate)
Ativan (Lorazepam)
Buspar (Buspirone)
Centrax (Prazepam)

Anti-histamine that can be prescribed for sleep

Benadryl

Individual	Job Title
Maureen Adams	Director of Nursing [CNYPC]
Dr. David Barry	Physician; Member of the Medical Review Board of the New York State Commission of Correction
Jeffrey Bea	Lieutenant, Attica [DOCS]
John Culkin	Director of Mental Health Services [DOCS]
Anthony DeVito	Associate Director of Quality Management [CNYPC] Former Satellite Unit Chief, Wende
Charles Gordon	Mental Health Program Specialist [DOCS]
Gary Greene	Superintendent, Great Meadow [DOCS]
Charles Herrmann	Associate Director of Quality Management for CNYPC; formerly Director of Risk Management for CNYPC
Leslie Kellam	Program Research Specialist III [DOCS]
Nancy Key	Forensic Unit Chief, Sing Sing [CNYPC]
Sharon Keyser	Unit Chief, Albion [CNYPC]
Loretta Klein	Retired (Formerly Forensic Unit Chief Shawangunk and Sullivan [CNYPC])
Frederick Lamy	New York State Commissioner of Correction
Dr. Mitchell Langbart	Psychiatrist, Former Acting Clinical Director, Auburn [OMH]
William Lape	Currently Superintendent at Marcy; was Deputy Superintendent at Five Points until June 2003 [DOCS]
Lucien Leclaire	DOCS Deputy Commissioner [DOCS]
Elaine Lord	Superintendent, Bedford Hills [DOCS]
Richard Miraglia	Associate Commissioner of Forensic Services [OMH]
Dr. Adele Pace	Former Acting Clinical Director [CNYPC]
Peter Russell	Forensic Unit Chief, Elmira [CNYPC]

Individual	Job Title
Dr. Donald Sawyer	Director of Operations [CNYPC]
Donald Selsky	Director of Special Housing [DOCS]
Dr. Aligmantas Shimkunas	Forensic Program Administrator; Unit Chief, Great Meadow [CNYPC]
Harold (Hal) Smith	Executive Director [CNYPC]
Jayne Van Bramer	Director for Quality Management [OMH]
Dr. Bruce Way	Assistant Director of Operations [CNYPC]
Larry Woodward	ICP Unit Coordinator, Elmira [DOCS]
Dr. Lester Wright	Deputy Commissioner and Chief Medical Officer [DOCS]