UNITED STATES DISTRICT COURT
SOUTHERN DISTRICT OF NEW YORK

DISABILITY ADVOCATES, INC.,
Plaintiff

-vs-

COMPLAINT

NEW YORK STATE OFFICE OF MENTAL HEALTH ("OMH"), JAMES L. STONE, COMMISSIONER OF MENTAL HEALTH, OMH SATELLITE MENTAL HEALTH UNIT CHIEFS JURGEN KARKER, SCOTT CLAIR, MICHELLE PETRINO, WAYNE CROSIER, KATHY CAVANAUGH, MICHAEL HILL, JOHN DUNN, PETER RUSSELL, AL SHIMKUNAS, THOMAS RYAN, DAVID BOYD, LORETTA KLEIN, ANTHONY DEVITO, NEW YORK STATE DEPARTMENT OF CORRECTIONAL SERVICES ("DOCS"), GLENN S. GOORD, COMMISSIONER OF DOCS, FACILITY SUPERINTENDENTS VICTOR HERBERT, JOHN BURGE, ELAINE LORD, DANIEL SENKOWSKI, GARY FILLION, FRANK TRACY, DAVID MILLER, FLOYD G. BENNETT, JR., THOMAS POOLE, GEORGE DUNCAN, CHARLES GRIENER, LEONARD PORTUONDO, BRIAN FISCHER, MICHAEL P. MCGINNIS, JAMES WALSH, THOMAS RICKS, EDWARD DONNELLY,
Defendants.

Plaintiff, Disability Advocates, Inc., a New York protection and advocacy agency, sues defendants on behalf of prisoners with mental illness in New York State and alleges:

Preliminary Statement

1. This action seeks declaratory and injunctive relief on behalf of prisoners with mental illness who are or who will be confined in the custody of the New York State Department of Correctional Services ("DOCS"). The New York State Office of Mental Health ("OMH") and DOCS defendants have continually and persistently ignored the serious mental health needs of the prison population in New York.

2. Plaintiff brings this action under 42 U.S.C. § 1983, the Eighth and Fourteenth Amendments of the United States Constitution, 29 U.S.C. § 794 (the Rehabilitation Act), and 42 U.S.C. § 12132 (the Americans with Disabilities Act of 1990). Plaintiff alleges that the defendants act with deliberate indifference to the serious medical needs of prisoners with mental illness by failing to provide adequate mental health services, including necessary inpatient and residential mental health programs, and by imposing punishments which aggravate the mental illness of prisoners. Defendants' conduct discriminates against prisoners with mental illness on the basis of their disability and constitutes cruel and unusual punishment in violation of law.

3. OMH and DOCS do not provide necessary treatment opportunities and access to programs for prisoners with mental illness. The failure to provide adequate treatment and programs causes mentally disabled prisoners to psychiatrically deteriorate and to engage in behavior symptomatic of their illnesses. Defendants' deliberate indifference to the serious mental health needs of prisoners in the New York State prison system has resulted in a disproportionately high number of prisoners with serious mental illness being housed in the harsh and punitive conditions of disciplinary isolated confinement.

4. In twenty-three hour disciplinary isolated confinement, special housing units ("SHU"), double-celled SHUs, and keeplock, the suffering of prisoners with mental illness is intensified and the severity of their mental illness is worsened by the near total lack of human contact and even more limited or non-existent treatment opportunities.

5. These abuses are systemic throughout the New York State prison system.

6. The DOCS prison population has increased more than three-fold since 1981 to more than 67,000 today. During the same time period, DOCS and OMH have observed an increase in the

incidence and severity of serious mental illness among the prison population. In 1987, OMH estimated that 8% of the prison population suffered from very substantial psychiatric disabilities warranting mental health services; another 16% were deemed to suffer from significant psychiatric disabilities. Based on these assertions, at least 16,000 prisoners suffer from significant to severe psychiatric illnesses.

7. Notwithstanding the increase in the incidence and severity of serious mental illness among the prison population, the number of inpatient beds at the Central New York Psychiatric Center, the only New York State psychiatric hospital to serve DOCS prisons, has not increased since 1981. The current number of beds is not sufficient to provide intensive psychiatric treatment to the scores of prisoners with serious mental illness who require it. There is also a lack of sufficient space in Intermediate Care Program units to accommodate the number of prisoners with mental illness in need of therapeutic housing. Staffing levels have not increased with the demand for services; defendants lack an adequate number of staff persons to handle the growing need for mental health evaluations, treatment, commitments, transfers, and discharge planning.

8. The failure to provide for the mental health needs of prisoners causes serious, and sometimes permanent, mental and physical deterioration. Prisoners with mental illness who have been neglected and deprived of adequate treatment while incarcerated are likely to be more severely mentally ill upon their release from prison than they would be otherwise; they are more likely to experience homelessness, less likely to trust mental health care providers, and less likely to seek necessary mental health care upon their release. Disregard for the treatment needs of prisoners with mental illness harms the prisoner and poses both a burden and a danger to the public at large.

Jurisdiction and Venue

9. This court has jurisdiction over these claims pursuant to 28 U.S.C. §§ 1331 and 1343. Plaintiff is entitled to declaratory relief pursuant to 28 U.S.C. § 2201. Venue is proper in this district under 28 U.S.C. § 1391(b).

Parties

10. Plaintiff Disability Advocates, Inc. ("DAI"), is a not-for-profit corporation, authorized to practice law under New York State law.

11. DAI is an authorized protection and advocacy agency under the Protection and Advocacy for Individuals with Mental Illness Act ("PAIMI"), 42 U.S.C. § 10801 et seq.

12. DAI has statutory authority to pursue legal, administrative and other appropriate remedies to ensure the protection of individuals with mental illness who are or will be receiving care and treatment in New York State. 42 U.S.C. § 10805.

13. DAI is pursuing this action to protect and advocate for the rights and interests of prisoners who are "individuals with mental illness" as that term is defined in 42 U.S.C. § 10802. DAI's constituents are prisoners with a significant mental illness or emotional impairment who reside in New York State prisons, which are "facilities" rendering care and treatment for mentally ill individuals as that term is defined in 42 U.S.C. § 10802.

14. Prisoners with mental illness on whose behalf this litigation is brought have each suffered injuries, or will suffer such injuries, that would allow them to bring suit against defendants in their own right. These prisoners with mental illness are housed in prisons throughout the State and are frequently transferred from one facility to another. Approximately 70% of the prison population is from the five boroughs of New York City.

15. Defendant New York State Office of Mental Health ("OMH") is 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.

16. Defendant James L. Stone is the Commissioner of OMH. He is responsible for the operation and administration of programs for the treatment of prisoners with mental illness confined in New York State correctional facilities. He is sued in his official capacity.

17. Defendants OMH Satellite Mental Health Unit Chiefs Jurgen Karker (Auburn Correctional Facility ("C.F.")), Scott Clair (Attica C.F.), Michelle Petrino (Bedford Hills C.F.), Wayne Crosier (Clinton C.F.), Kathy Cavanaugh (Coxsackie C.F.), Michael Hill (Downstate C.F.), John Dunn (Eastern C.F.), Peter Russell (Elmira C.F.), Jurgen Karker (Five Points C.F.), Al Shimkunas (Great Meadow C.F.), Thomas Ryan (Green Haven, C.F.), David Boyd (Sing Sing C.F.), Loretta Klein (Shawangunk C.F. and Sullivan C.F.), and Anthony DeVito (Wende C.F.) are all Forensic Unit Chiefs of OMH Satellite Mental Health Units in New York State correctional facilities. These defendants are sued in their official capacities.

18. Defendant New York State Department of Correctional Services ("DOCS") is the agency created by the State of New York for the purpose of operating prison facilities within New York State.

19. Defendant Glenn S. Goord is the Commissioner of DOCS. He is responsible for the operation and administration of all facilities within the department. He is sued in his official capacity.

20. Defendants Superintendents Victor Herbert (Attica C.F.), John Burge (Auburn C.F.), Elaine Lord (Bedford Hills C.F.), Daniel Senkowski (Clinton C.F.), Gary Fillion (Coxsackie C.F.), Frank Tracy (Downstate C.F.), David Miller (Eastern C.F.), Floyd G. Bennett, Jr. (Elmira C.F.), Thomas Poole (Five Points C.F.), George Duncan (Great Meadow C.F.), Charles Greiner (Green Haven C.F.), Leonard Portuondo (Shawangunk C.F.), Brian Fischer (Sing Sing C.F.), Michael P. McGinnis (Southport C.F.), James Walsh (Sullivan C.F.), Thomas Ricks (Upstate C.F.), and Edward Donnelly (Wende C.F.) are all Superintendents of maximum security prisons in New York State. These defendants are sued in their official capacities.

Facts

Inadequate Mental Health Care Programs and Resources

Overview

21. In New York State, the delivery of mental health care and treatment to prisoners with mental illness is the joint responsibility of the Commissioner of DOCS and the Commissioner of OMH. The Commissioner of DOCS, in cooperation with the Commissioner of OMH, is responsible for establishing programs for the treatment of prisoners with mental illness confined in state correctional facilities who are in need of psychiatric services but who do not require hospitalization. N.Y. Corrections Law § 401.

22. The administration and operation of the treatment programs established pursuant to Corrections Law § 401 are the responsibility of the Commissioner of OMH, as is the operation of Central New York Psychiatric Center ("CNYPC"). N.Y. Corrections Law § 401; N.Y. Mental Hygiene Law § 7.17.

23. The Superintendent of each facility is responsible for the supervision and management of the facility and the care, custody and safety of all prisoners under his or her immediate jurisdiction. N.Y. Corrections Law § 18.

Structure of the Mental Health Care System

24. The CNYPC provides both inpatient and outpatient services to the prisoners in DOCS correctional facilities. Inpatient services are provided at the psychiatric hospital, CNYPC, in Marcy, New York. Outpatient services are provided at DOCS correctional facilities through a system of OMH Satellite Mental Health Units and OMH Mental Health Units, each with a corresponding catchment area of correctional facilities.

25. OMH Satellite Mental Health Units are located in twelve of the seventeen maximum security prisons. OMH Satellite Mental Health Units have full time staff and operate Residential Crisis Treatment Programs ("RCTP") that serve all of the prisons within the Satellite Mental Health Units' catchment area, including medium and minimum security prisons. The RCTP consists of mental observation cells and a dorm area where prisoners may be admitted and housed within the Satellite Mental Health Unit. Prisoners in the RCTP either are eventually returned to their respective housing areas or committed to the inpatient unit of CNYPC.

26. Five maximum security prisons, including Southport C.F. and Upstate C.F. which consist only of cells for twenty-three hour disciplinary confinement, do not have an OMH Satellite Mental Health Unit. Each of those five maximum security prisons and seven out of 37 medium security facilities have OMH Mental Health Units ("MHU"). The MHUs do not have any full time mental health or medical clinicians and require only a minimum of eight hours of psychiatric services per week.

27. Fourteen medium and minimum security DOCS facilities in the catchment area of an OMH Satellite Mental Health Unit or MHU have limited on-site mental health services including a part-time psychiatrist. Twenty-three medium and minimum security DOCS facilities in the catchment area of an OMH Satellite Mental Health Unit or MHU have limited on-site mental health services but do not provide the services of a psychiatrist on site.

28. Intermediate Care Programs ("ICP") are located at maximum security prisons which have OMH Satellite Mental Health Units. ICPs are DOCS programs that are jointly staffed by OMH and DOCS. Prisoners housed in the ICPs have been deemed unable to function in the general population due to the effects of a mental illness.

29. OMH utilizes a classification system which designates each mentally ill prisoner with an OMH "service level designation" of 1, 2, 3, 4, or 6. There is no level 5. A designation of level 6 indicates that the prisoner "does not require or is not appropriate for Mental Health services," level 4 indicates "need for and/or interest in psychotherapy," level 3 indicates "current or future need for short term chemotherapy for minor disorders such as anxiety, moderate depression, or adjustment problems," level 2 indicates "psychiatric treatment for major psychiatric disorder" or "current prescription of medication for a major psychiatric disorder," and prisoners in need of the highest level of care are designated a level 1. Level 1 indicates "medication monitoring by psychiatric nurse," "admission to CNYPC," "day treatment program (AVP or ICP)," or "placement in a Satellite Unit bed." OMH Treatment Needs/Service Level Designation Form 167.

30. Prisoners with mental illness are frequently switched from one OMH needs level classification to another, from therapeutic housing in an ICP setting to more restrictive non-therapeutic housing, and from one correctional facility to another. Such changes often drastically and inappropriately alter the mental health treatment provided or available to the prisoner.

31. Despite their legal obligation to do so, defendants have systematically failed and refused to consistently provide prisoners with mental illness with medically necessary mental health care, including but not limited to inpatient hospitalization when needed, and intermediate level mental health care within the prison. Even when prisoners with mental illness clearly improve and benefit from treatment in a therapeutic environment, they are regularly returned to non-therapeutic housing and even to isolated twenty-three hour confinement within the prisons. As a result, and as set forth more fully below, the serious mental health needs of New York State prisoners are not being met.

Insufficient Mental Health Care in Twenty-Three Hour Confinement

32. New York State confines close to 6,000 of its 67,000 prisoners in twenty-three hour isolated confinement housing areas: SHUs, double-celled SHUs, and keeplock. These disciplinary confinement units are, in operation and effect, isolation units.

33. In SHU and keeplock, prisoners are confined in small cells for twenty-three hours each day. Single cells in DOCS are approximately six feet by ten feet (they range in size from between 48 and 62 square feet). The new double-celled SHU cells at Five Points C.F. and Upstate C.F. are eight feet by thirteen feet.

34. SHU prisoners are allowed out of their cells only one hour per day, during which they are locked alone in a small cage outside. The recreation cages vary somewhat in size. At Southport C.F., they are eight feet by sixteen feet, twelve feet high with a bare concrete floor and no equipment. At the new double-celled SHUs at Five Points C.F. and Upstate C.F., the yard cages are attached directly to each SHU cell. These recreation cages are only eight feet by seven feet.

35. In order to minimize their contact with others, SHU and keeplock prisoners are made to eat alone in their cells, cannot see other prisoners from their cells, and are not permitted to work at prison jobs, attend programs or engage in other rehabilitative activities.

36. Despite their known mental illness, prisoners with mental illness subject to DOCS disciplinary sanctions are frequently placed into these psychologically punishing twenty-three hour isolated confinement housing areas. Confinement in twenty-three hour isolated confinement housing areas is known to exacerbate mental illness.

37. In SHU and in blocks where a majority of prisoners are under keeplock, the noise level inside is often deafening because prisoners with mental illness scream and bang on their cell walls.

38. In the double-celled SHU twenty-three hour confinement housing areas, the conditions are similar to SHU except for extremely close and unbroken contact with one other cellmate/prisoner. The double-celled SHU cells have a solid cell door with one small opening that prisoners must use to speak to staff, including mental health and other medical staff. For prisoners with mental illness, the close and confined shared quarters in double-celled SHUs frequently exacerbate their mental illness.

39. Prisoners in twenty-three hour isolated confinement housing areas have extremely limited opportunities to participate in any form of mental health therapy. Often the only contact with mental health staff occurs during rounds when OMH staff walk through the housing unit and may stop and speak to prisoners from through the bars at the front of their cell or though a slot in the solid door of their cell, all within earshot of neighboring cells and in the presence of a cellmate in the double-celled SHUs.

40. Frequently the only treatment offered or available in twenty-three hour isolated confinement is medication, which is dispensed by a nurse who makes rounds in SHU. It is difficult for SHU prisoners to discuss side effects from and concerns about medication because of the lack of privacy and because mental health staff who make rounds in SHU devote little time to meeting with their patients. Prisoners who suffer from side effects, who feel depressed, or who may believe that they no longer need medications, often begin to refuse medications. Little is done to discuss or to encourage compliance with medication regimes. Prisoners who become non-compliant with ordered medication regimens frequently psychiatrically deteriorate without intervention by mental health staff, and indeed are dropped from the list of OMH patients despite their known serious mental health needs.

41. Many mentally ill individuals cannot tolerate prolonged, isolated confinement without significant, and often life-threatening, exacerbation of their mental illness. Twenty-three hour isolated confinement has a serious adverse impact on persons suffering from depression, schizophrenia and other psychiatric disorders and may cause drastic decompensation in such persons, including increased disorientation, delusional thinking, paranoid thoughts, suicidal thoughts and thoughts of self-harm, and self-injurious and suicidal acts.

42. The lack of adequate mental health treatment to those prisoners housed in twenty-three hour isolated confinement intensifies their suffering and psychiatric deterioration.

43. OMH and DOCS have persistently resisted identifying and removing from twenty-three hour isolated confinement prisoners with mental illness who psychiatrically deteriorate as a result of the stringent conditions of confinement in isolation.

44. OMH and DOCS have persistently resisted acknowledging the deleterious effects of long-term isolation on the mental health of prisoners housed under these conditions.

45. As described in detail below, the serious consequences of the failure of defendants to restrict the placement of prisoners with mental illness into, and their failure to intervene and to remove prisoners with mental illness from, twenty-three hour isolated confinement has resulted in a disproportionate percentage of suicides within the population of prisoners housed in SHUs, double-celled SHUs and keeplock.

A Cycle of Torment: Lack of Adequate Mental Health Care Results in the Placement of Prisoners with Mental Illness in Isolated Confinement, Which in Turn Causes Greater Psychiatric Harm

46. As a consequence of the symptoms of their illnesses, many prisoners with mental illness are incapable of conforming to the prison regimen and rules. The lack of adequate mental health treatment makes this problem more severe and widespread.

47. Inadequate mental health treatment in the prisons results in prisoners with mental illness suffering serious psychiatric deterioration and engaging in symptomatic behaviors which may include violent or assaultive behavior; acts of self-mutilation and self-harm; attempts or acts of suicide; depression, isolation and withdrawal; failure to keep clean and other unhygienic behavior; smearing feces on themselves and their cells; setting fires; screaming; hoarding or refusing food; and flooding their cells with water from the toilet.

48. These behaviors, symptomatic of serious psychiatric deterioration, violate DOCS rules for prisoner conduct. Prisoners with mental illness are frequently sentenced to periods of isolated confinement for engaging in such symptomatic conduct.

49. As a direct result of the defendants' failure to provide adequate mental health care, the disciplinary housing areas of New York State prisons are disproportionately filled with the mentally ill.

50. Once punished with confinement in a twenty-three hour isolated confinement housing area, many prisoners with mental illness become even less able to conform to prison rules because their mental conditions worsen. As a result, many prisoners with mental illness, who are suffering from their illnesses and who are serving time in isolated confinement, become subject to additional disciplinary sanctions including additional consecutive periods of isolated confinement.

51. Many prisoners with mental illness enter a cycle of placement in isolated confinement; the consequent exacerbation of mental illness; extreme decompensation, often to the point of dangerousness to self or others; commitment to CNYPC; a return to prison and isolated confinement after only a brief inpatient stay at CNYPC; followed by a repeated mental deterioration in twenty-three hour confinement leading to subsequent re-commitment to CNYPC.

52. Other prisoners with mental illness in twenty-three hour isolated confinement decompensate and become increasingly ill, but do not receive necessary hospitalization or other treatment for their decompensation. These prisoners may spend lengthy periods of isolated confinement while floridly mentally ill without receiving necessary treatment or release from their torment.

53. Because DOCS regulations impose no upper limit on the duration for which prisoners may be confined in twenty-three hour isolated confinement, many prisoners with mental illness spend years housed under these harmful conditions, isolated and virtually untreated, with many more years of isolated confinement ahead of them.

Insufficient Emergency Mental Health Care in Observation Cells

54. Many prisoners with mental illness who have been identified to be at risk of suicide or to be a danger to themselves or others, are secluded in observation cells in the prison Satellite Mental Health Units for twenty-three or even twenty-four hours a day.

55. Prisoners held in observation cells often are deprived of all property and furnishings except for mats on the floor, and are held with limited bedding or clothing.

56. Often the only treatment available to prisoners in observations cells is medication. No rehabilitative activities, therapy, or programs are offered.

57. Acutely mentally ill prisoners remain alone, almost naked, under these conditions for periods of many days and sometimes weeks before they are transferred to CNYPC for mental health treatment or simply are transferred back to the cell where they previously psychiatrically deteriorated.

58. Prolonged seclusion of acutely psychotic persons under the conditions in the observation cells presents a substantial risk of serious harm and can cause increased disorientation, delusional thinking, paranoid thoughts, suicidal thoughts, thoughts of self-harm, and self-injurious and suicidal acts.

Prisoner Suicides

59. The serious consequences of the failure of defendants to restrict the placement of prisoners with mental illness into, and their failure to intervene and to remove prisoners with mental illness from, twenty-three hour isolated confinement is evident from the disproportionate percentage of suicides within the population of prisoners housed in isolated confinement. For each year from 1998 through 2001, from 30% to 50% of the suicides for the entire prison population occurred within

the 8% of the prison population confined in twenty-three hour isolated confinement housing (SHU, double-celled SHU and keeplock). According to State Commission of Correction ("SCOC") investigations of suicides, deficient mental health treatment and the stresses of isolated twenty-three hour confinement have been significant factors leading to suicide.

60. All of the following factual information concerning the suicides of prisoners in DOCS custody is derived from the final report on each death which was prepared by the New York State Commission of Correction ("SCOC") and obtained from them pursuant to the Freedom of Information Law (Public Officers Law § 87). The SCOC is the state oversight agency which investigates and oversees correctional facilities. Due to the confidential medical information described, random initials have been substituted for the proper names of the prisoners.

Suicide of Prisoner A.B.

61. On June 5, 2000, prisoner A.B. died of suicidal hanging at Elmira C.F. A.B. had a known lengthy history of suffering from serious mental illness from the age of nineteen, including a history of suicidal tendencies.

62. A.B.. had been held at CNYPC from September 10, 1999 through January 6, 2000 and then held at the Oneida County C.F. on a mental health tier (a housing area designated for prisoners with mental illness).

63. On May 3, 2000, A.B. was transferred from Oneida County to DOCS and housed at Elmira C.F. Reception Center. Due to his extensive mental health history, he was admitted to the RCTP in the OMH Satellite Mental Health Unit for evaluation and monitoring.

64. On May 14, 2000, even though his neurodiagnostic work-up was not completed, A.B. was released from the Satellite Mental Health Unit to a reception tier in general population (where new prisoners are housed while their classification and housing assignments are determined).

65. Within two days of his transfer to general population, A.B. expressed to OMH staff that he wanted to die and that voices were telling him to hurt himself. Despite his existing mental distress and his known history of suicidal tendencies, he was not immediately transferred back to the Satellite Mental Health Unit.

66. On May 20, 2000, A.B. was transferred to the Satellite Mental Health Unit after he was found with a sheet tied around his neck.

67. On May 23, 2000, his primary therapist described A.B. as having a positive death wish and being hopeless and helpless. A.B. was kept in an observation cell in the OMH Satellite Mental Health Unit until May 31, 2000, when he was inappropriately transferred back to the reception tier and not to a therapeutic mental health housing program.

68. On June 5, 2000, A.B. was found hanging from a bedsheet in his cell on the reception tier. He was pronounced dead approximately one hour later.

69. The SCOC recommended that OMH address with staff "effective treatment in a safe environment, including timely use of the Intermediate Care Program, regardless of reception/classification status, for seriously ill patients with high impulsivity, history of suicide attempt, or propensity for rapid decompensation under stress. These patients may no longer be appropriate for the RCTP, *but need enhanced supervision, observation or precautions in a therapeutic setting.*" Final Report in the Matter of the Death of A.B., March 2001, p. 5, (emphasis supplied).

70. SCOC recommended that OMH undertake a review of their policies and procedures "regarding the provision of effective treatment in a safe environment; specifically, those governing timely placement in safer settings of inmates who have experienced difficulty adjusting to, or possess the potential to have problems coping with, general population for psychiatric reasons." Id.

71. OMH responded defensively to the SCOC preliminary report , indicating that because A.B. was a prisoner at Elmira C.F. Reception Center not Elmira C.F., he was not eligible for placement in the ICP notwithstanding his clinical need for a therapeutic treatment housing placement. SCOC determined that no such distinction for admission to ICP existed, that DOCS does not have any policy which would prohibit placement of a reception classification prisoner in the ICP, and that such placements had, in fact, previously been made. Moreover, SCOC learned that A.B. had been fully classified by May 9, 2000, and therefore was no longer a reception/classification prisoner.

72. In review of this matter, the New York State Medical Review Board appropriately found that "reception status is irrelevant to the objective of providing effective treatment in a safe setting." Nothing in the OMH response reflected a clinical basis for the limited mental health care provided to this seriously mentally disabled individual.

Suicide of Prisoner C.D.

73. C.D. was committed to CNYPC from July 17, 1998 through January 27, 1999. His diagnosis was schizophrenic disorganized type. He was discharged from the CNYPC pre-release ward where he had been assisting in preparation of a discharge plan for his pending release on parole.

74. CNYPC indicated in a discharge plan that C.D. needed to be linked to psychiatric aftercare services which should include regular contact with a therapist, continual prescription of psychotropic medications, and regular visitations with a psychiatrist to monitor his medications and his overall mental status. He was discharged from CNYPC to Downstate C.F. on January 27 and sent to Sullivan C.F. on February 5, 1999, to await community placement.

75. Although CNYPC specifically recommended that C.D. be housed in the ICP at Sullivan C.F. pending his release from custody. C.D. was denied ICP placement at Sullivan C.F. The basis of the denial was that he was not expected to remain at Sullivan C.F. for a lengthy period of time. This refusal of intermediate care placement was not based upon an exercise of clinical judgment and, in fact, was done without Sullivan C.F. OMH staff ever even interviewing C.D.

76. C.D. deteriorated rapidly in general population. On February 11, 1999, C.D. was admitted to the OMH Satellite Mental Health Unit after exhibiting bizarre behavior.

77. C.D. became non-compliant with medication and was involved in two violent incidents on March 29 and March 30. He was served with several disciplinary tickets for his misbehavior during the incidents and was taken from the Satellite Mental Health Unit and placed into disciplinary twenty-three hour isolated confinement housing in the Sullivan C.F. SHU.

78. On April 16, C.D. sent a note to the Commissioner of DOCS and the OMH staff at Sullivan C.F. threatening suicide if he was moved to another facility.

79. A part-time psychiatrist then recommended that C.D. be placed in an observation cell in the OMH Satellite Mental Health Unit. He was taken back to the Satellite Mental Health Unit on April 23. While in the observation cell, C.D. was evaluated for possible transfer to CNYPC. He was not admitted to CNYPC. Subsequently, OMH approved his return to twenty-three hour isolated confinement in the Sullivan C.F. SHU.

80. On April 28, C.D. refused to speak with the psychologist who conducted rounds in SHU. On April 30, he was informed by parole staff that his parole date had been suspended due to his recent misbehavior and disciplinary tickets.

81. On May 3, 1999, C.D. was found hanging in his cell.

82. The SCOC recommended that a quality assurance review be conducted to determine why C.D. had not been housed in ICP upon transfer to Sullivan C.F. as specifically recommended in the CNYPC discharge plan. The SCOC found that "[t]o be denied admission to the ICP because he was not expected to remain at Sullivan C.F. long enough to benefit from the program is *not sound clinical reasoning*." Final Report in the Matter of the Death of C.D., December 1999, p.4, (emphasis supplied).

83. The SCOC further recommended that Sullivan C.F. develop and implement procedures which require close observation and intensive care management for patients observed to be refusing medications, decompensating or acting out.

84. The SCOC indicated that the notification to C.D. by parole on April 30, that his parole date had been suspended, was sufficient to alert OMH staff that C.D. was potentially at risk for life-threatening behavior. SCOC recommended that whenever an OMH Level 1 or 2 prisoner is decompensating in the SHU, enhanced security and supervision should be ordered for such prisoners, and more frequent supervisory checks should be performed until such prisoners can be transferred to a secure area of the facility designated for OMH cases.

85. OMH does not track its patients and former patients in the manner recommended by SCOC. There are no procedures in place to guarantee that OMH has knowledge about triggering events in the lives of prisoners with a known history of mental illness. OMH is not routinely and systematically informed of misbehavior, disciplinary hearings and decisions, or notifications about parole decisions or immigration proceedings.

Suicide of Prisoner E.F.

86. E.F. was incarcerated in 1982 to serve a term of fifty-three years to life. In 1984, he was hospitalized at CNYPC and discharged with a diagnosis of hallucinogen hallucinosis and antisocial personality disorder. OMH determined that he was defiant and considered him to be potentially assaultive. For several years he refused medication but remained an OMH active case as a self-referral for insomnia and paranoid ideation. In 1994, E.F. was designated as an OMH level 3 (i.e., it was determined that he might need mental health services).

87. E.F.'s disciplinary misbehavior escalated over the years, and he spent significant periods of time under keeplock and in SHU detention.

88. In June 1995, E.F. was accused of two assaults on staff. As a result, he was transferred to Southport C.F. to serve four years of SHU time. OMH did not intervene at his disciplinary hearing either to indicate that his assaultive behavior may have been due to his mental illness or to recommend that he remain at a facility with full-time mental health staffing.

89. E.F. was transferred to Southport C.F., which is an all-SHU prison and does not have an OMH Satellite Mental Health Unit on the premises. Prisoners' mental health services are limited at Southport C.F. OMH staff from Elmira C.F.'s Satellite Mental Health Unit provide a part-time presence at Southport C.F.

90. Three months after E.F.'s transfer to Southport C.F., an OMH evaluation conducted on September 17, 1995, determined that he did not need any mental health services.

91. While at Southport C.F., E.F. accumulated misbehavior reports resulting in cumulative SHU time up to the year 2010.

92. In 1997, E.F. was referred to OMH by a medical nurse who reported that he was "extremely delusional." However, after assessing E.F., OMH determined that there was no evidence of mental illness. OMH did not make any contact at all with E.F. after 1997.

93. On March 6, 2000, E.F. committed suicide by hanging.

94. The SCOC Final Report on the death of E.F. states that "[i]t is a well established fact that inmates serving long term sentences in SHUs are likely to decompensate due to extended periods of isolation and sensory deprivation. CNYPC Outpatient Policy and Procedure, in accordance with ACA [American Correctional Association] Standards, states that all SHU inmates are to be evaluated every 90 days for documentation according to standards. The NYS Office of Mental Health, Bureau of Forensic Services is in violation of CNYPC and ACA Standards regarding 90 day reviews. This is of significant concern to the Commission in recognition of the *obvious long-term effects of segregation on inmates*." Final Report in the Matter of the Death of E.F., September 2000, p. 3 (emphasis supplied).

95. SCOC determined that OMH was not in compliance with minimum staffing levels at Southport C.F. and that it failed to conduct evaluations of SHU prisoners every 90 days as required by ACA standards.

96. The OMH response to the SCOC preliminary report asserted that it did not have enough staff to comply with the required 90 day reviews. OMH further asserted that, in any event, it actually was in compliance with ACA standards because the resources were outposted from Elmira C.F.

97. SCOC stated in its final report that OMH could not claim a failure of 90 day reviews due to lack of staff at the same time that it was asserting sufficient staffing levels through outposting from Elmira.

Suicide of Prisoner G.H.

98. Prior to his admission to DOCS custody in 1997, G.H. had been hospitalized for manic depression in 1993 and 1994. The evaluation conducted by OMH in 1997 did not reflect this prior psychiatric history of hospitalizations.

99. In 1999, G.H. was placed on work release, which was revoked when he went AWOL and then was arrested for assaulting a girlfriend. He was given a disciplinary sentence of six months SHU confinement and an additional six months incarceration was added to his sentence.

100. Upon admission to the SHU at Fishkill C.F., G.H. was evaluated by OMH. At that time, G.H. revealed his prior history of psychiatric hospitalizations. However, OMH determined that G.H. was not in need of psychiatric services. He was given the lowest OMH needs classification level, level 6 (i.e., not in need of services). OMH staff did not obtain or even seek to obtain any information concerning his prior hospitalizations.

101. G.H. was re-evaluated by OMH on December 22, 1999. At this evaluation he admitted to being anxious and depressed, and he described his previous suicide attempts. He reported that he took the drug Elavil in the past and wanted to give it another try. Thereafter, OMH prescribed Elavil for G.H.

102. On January 17, 2000, G.H. was evaluated by OMH again. G.H. reported that he was sleeping night and day and that he found the SHU too stressful. OMH did not provide any counseling by mental health staff about coping with stress in SHU.

103. On January 27, 2000, G.H. requested that his medication be changed to Sinequan. OMH then prescribed Sinequan for G.H.

104. On March 3, 2000 and on April 7, 2000, G.H. complained about difficulties with Sinequan. OMH increased his dosage of Sinequan on April 7, 2000.

105. On April 28, 2000, a SHU officer submitted a mental health referral which indicated that G.H. kept repeating: "they are going to kill me and my family, they have my address, nobody is doing anything about it, I'll handle it my way."

106. DOCS security staff placed G.H. on a special watch until he could be evaluated during mental health office hours on Monday May 1, 2000.

107. On May 1, 2000, OMH staff found that G.H. was paranoid and complaining that he was hearing prisoners' voices threatening to kill him. OMH did not recommend that G.H. be removed from SHU.

108. On May 31, 2000, G.H. complained for a third time about Sinequan saying that it made him too "jittery." On June 2, 2000, the psychiatrist changed his medication to Trazadone.

109. On June 2, 2000, G.H. was anxious about transfer to another facility and he complained of "being frustrated with fears for his family safety and felt that someone should be doing more to address the issue." He denied hearing voices or having thoughts of self-harm. The mental health worker reported that G.H. was anxious but not as much as he had been in April.

110. On June 3, 2000, G.H. refused recreation and refused the lunch meal. When another prisoner returned from recreation, he observed G.H. hanging in his cell. G.H. was pronounced dead shortly thereafter.

111. In the SCOC Final Report on the death of G.H., the recommendations included: an overall effort to improve care management of prisoners with mental illness in SHU; better documentation and evaluation of prisoner safety concerns versus possible hallucinations; and better documentation and follow-up on referrals to security and on the results of investigations as part of the prisoner's treatment plan.

112. The Medical Review Board indicated that it is unacceptable to have a prisoner on a one-to-one watch by security without mental health intervention until the next business day.

113. OMH responded defensively to the SCOC preliminary report. OMH claimed that although there were recording errors, there was no causality between them and the prisoner's death. OMH did not address in its response its failure to contact previous mental health providers concerning the patient's treatment history. OMH blamed the delay between the suicide watch initiated by security and mental health assessment of G.H. on the fact that Fishkill is an OMH needs Level 2 provider. However, OMH did not explain, based on this noted problem and deficiency, why it failed to have G.H. moved to a Level 1 facility after the suicide watch.

114. In summary and as set forth below, the inadequacy of the mental health care programs and resources to address the serious mental health needs of prisoners is deficient across the board. There is insufficient long-term inpatient care, intermediate care, and emergency care, and there is a failure to care for, or intervene to remove, prisoners with mental illness housed in harsh twenty-three hour isolated confinement housing even when isolation is clearly exacerbating their illness or causing serious mental deterioration. This cumulative failure, at all levels of need, to provide adequate mental health treatment results in serious and in some cases fatal consequences for prisoners with mental illness whose psychiatric needs are not met.

Insufficient Long Term Inpatient Mental Health Care

115. Prisoners with mental illness who, due to the severity of their illness, require long-term inpatient care at a psychiatric hospital are not provided with this essential care. DOCS and OMH do not have *any* program to provide extended inpatient psychiatric treatment to prisoners; the only inpatient psychiatric facility for prisoners, CNYPC, has only 187 beds for a population of more than 67,000 prisoners and is operated as a short-term placement only.

116. The immediate consequence of the insufficient number of available inpatient beds is two-fold: prisoners with mental illness experiencing grave psychiatric need either suffer an undue delay in admission or are prematurely discharged from CNYPC.

117. While awaiting admission to CNYPC, many prisoners with mental illness are held for twenty-three or even twenty-four hours a day in secluded observation cells in the OMH Satellite Mental Health Units for evaluation due to their severe psychiatric deterioration or acts of self-harm. Frequently they are held alone in these small cells for many days or even weeks while they wait to be admitted to CNYPC.

118. Many prisoners with mental illness, who suffer severe psychiatric deterioration and are admitted to CNYPC, are returned to prison prematurely even though they have a continuing need for inpatient care to stabilize their illness and to ensure that they remain stabilized.

119. The problem of the lack of necessary inpatient beds has been so severe that at times CNYPC has operated at or above capacity on a "one-for-one" basis, wherein a facility must take a prisoner back from CNYPC in order to send one in.

120. Prison outpatient services available to prisoners with mental illness who are discharged from CNYPC fail to provide appropriate treatment and services to meet the prisoners' known mental health care needs. Prison mental health staff frequently do not follow, or quickly modify, the treatment plan developed at CNYPC that directs the mental health treatment a prisoner should receive upon release back to the prison.

121. The consequences of premature release from CNYPC often include serious painful episodes of psychiatric deterioration. Some prisoners with mental illness quickly psychiatrically deteriorate upon their return to prison and then must be treated in a crisis mode, forcibly medicated

in an emergency situation after an agonizing return to an extremely psychotic state. Other mentally disabled prisoners released prematurely from CNYPC attempt or commit suicide, mutilate themselves, or stop complying with the limited treatment provided by prison mental health staff.

122. Another consequence of the limited available inpatient hospital care is that acute care is rarely offered to prisoners with mental illness unless they are deemed to be an imminent danger to self or others. Severely disabled prisoners may be gravely ill and suffering, exhibiting extreme paranoia, experiencing depression or delusions, but until they actively engage in behavior to injure themselves or pose an imminent threat to others, they often are not even evaluated for admission to CNYPC or are denied admission despite their serious medical need.

123. When prisoners with mental illness refuse their medication, prison mental health staff frequently fail to inquire into the reasons for the refusal or to attempt to persuade the patient to accept the treatment, or to modify the treatment. Instead, the prisoner often is deemed to be uncooperative and is discharged from OMH services despite a diagnosis of a serious mental illness and recent hospitalization at CNYPC. In such a case the prisoner almost inevitably psychiatrically decompensates due to the lack of treatment.

124. This failure to provide appropriate treatment in prison and to provide long-term inpatient care causes many prisoners with serious mental illness to repeatedly cycle back and forth between prison and CNYPC. The repeated cycle of deprivation of adequate treatment leading to psychiatric crisis leading to hospitalization is extremely detrimental to individuals with serious mental illness. It often becomes increasingly difficult to restore these individuals from a mentally deteriorated or psychotic state to some semblance of normal functioning, and frequently these individuals become increasingly distrustful of OMH mental health staff who do nothing to interrupt the cycle of their torment.

Insufficient Intermediate Level Residential Mental Health Care

125. Many prisoners with mental illness require mental health services provided in an intermediate level therapeutic residential treatment program rather than an acute care hospital setting.

126. Defendants provide only 513 therapeutic residential treatment beds in Intermediate Care Programs ("ICP") for the entire population of prisoners with mental illness. These ICPs are located within DOCS prison facilities and are staffed jointly by DOCS and OMH staff. The ICPs are intended to provide more intensive therapies and programs than are available to prisoners housed in the general population.

127. The 513 ICP beds available are insufficient to provide for the numerous prisoners with mental illness who are known by DOCS and OMH to be in need of intermediate level residential mental health treatment.

128. Many prisoners with mental illness who have committed disciplinary infractions are barred from ICP placement even though they are in need of residential mental health treatment. No other therapeutic residential treatment program is available to treat them.

129. Prisoners with mental illness for whom a therapeutic residential treatment program is clinically appropriate are barred from participating in the ICPs due to the lack of bedspace, their current or prior disciplinary history, or other non-clinical reasons. This failure to provide necessary intermediate mental health care for these prisoners with mental illness often results in increased psychiatric deterioration, increased frustration trying to cope with the conditions of their confinement, increased incidents of misconduct borne of their inability to cope, and a decrease in programs and work opportunities.

Representative Constituents

130. All of the plaintiff's representative constituents are mentally ill adult residents of New York State and prisoners of the New York State Department of Correctional Services. Many of them have been confined to SHU, keeplock, double-celled SHU or administrative segregation at some time during the period of their incarceration. Many of them have been repeatedly held in OMH Satellite Mental Health Unit observation cells, ICP housing areas and have been committed to CNYPC. Each has an extensive history of mental illness well known to DOCS and OMH.

131. Due to the confidential medical information described, random initials have been substituted for the proper names of the representative constituents.

<u>Prisoner I.J.</u>

132. I.J., a diagnosed schizophrenic with borderline intellectual functioning, has been committed to CNYPC on twenty-nine separate occasions since his incarceration in 1981.

133. I.J. has a history of being suicidal when he is mentally decompensated. His admissions to CNYPC have been precipitated by depressed and sometimes self-abusive behaviors, as well as regressive behaviors such as defecating and urinating on the floor of his cell and becoming withdrawn and mute.

134. I.J. frequently suffers from hallucinations which are paranoid, persecutory and command self-harm. On numerous occasions from 1993 through 1996, he became severely decompensated, experienced paranoia and auditory hallucinations, and was admitted to CNYPC.

135. I.J. has spent a large portion of his incarceration housed in twenty-three hour isolated confinement in SHU. He has repeatedly suffered serious psychiatric deterioration in SHU.

136. During the occasions that he has been hospitalized at CNYPC or housed in an OMH Satellite Mental Health Unit and has accepted medication, he has not presented behavioral problems and has functioned markedly better than in isolated confinement.

137. In May 2000, while housed in the ICP at Great Meadow C.F., I.J. was again suffering a period of serious psychiatric deterioration. During that period, I.J. was sentenced to 180 days SHU time for two incidents of use of abusive language with no testimony from mental health staff requested or proffered at the disciplinary hearings.

138. I.J. was transferred to SHU where his deterioration escalated. According to a misbehavior report issued on May 24, 2000, I.J. refused to obey orders to turn the light on in his cell or to remove his jumpsuit from the cell gate; he reportedly began yelling threats at the corrections officer, ripped the light bulb from his wall and smashed it against the sink and toilet in his cell.

139. The misbehavior report indicates that OMH staff were notified and came to speak to I.J. after which he was escorted without incident to the OMH Satellite Mental Health Unit for observation.

140. On the date of his hearing, June 8, 2000, I.J. again was transferred to an observation cell in the OMH Satellite Mental Health Unit due to agitated behavior and smearing feces. He was reportedly exhibiting delusional thinking, refusing to eat and refusing medication.

141. I.J. did not appear at the hearing regarding the May 24 incident. OMH was not consulted by the hearing officer and did not testify at the disciplinary hearing. I.J. received one year in SHU for destroying state property, refusing a direct order, and using threatening language.

142. Shortly after his June 8 admission to an OMH observation cell, I.J. was returned to SHU from the observation cell at his request. He was transferred back to twenty-three hour isolated

SHU confinement without having accepted medication and without any indication that his condition had stabilized. No efforts to encourage compliance with medications or to consult with CNYPC are recorded in his mental health record.

143. I.J. continued to psychiatrically deteriorate in SHU. In August 2000, he was admitted again to the OMH Satellite Mental Health Unit for observation. His behavior was described as being loud and yelling, he reported that he was hearing voices, seeing ghosts, and that he was experiencing suicidal ideation.

144. Despite the OMH-observed and recorded paranoia and delusions for the two days following his admission to the OMH Satellite Mental Health Unit, I.J. was transferred back to his SHU cell on August 7, 2000. He was not seen again by OMH until September 21, 2000 when DOCS staff requested OMH intervention.

145. On September 21, 2000, DOCS staff referred I.J. to mental health staff due to his "strange behavior." No description of his behavior was recorded, and I.J.'s OMH record does not document any intervention by OMH staff.

146. I.J. was subsequently seen by OMH staff approximately every two to three weeks during rounds in SHU.

147. In October 2000, OMH noted that I.J. was compliant with his medications and that he requested an increase in medication because he was seeing ghosts.

148. The following month, I.J. began to suffer severe psychiatric deterioration again. He became medication non-compliant and refused to leave his cell to meet in private with OMH staff.

149. On November 9, 2000, I.J.'s medication orders were discontinued because he had been refusing to take medication. No efforts to encourage compliance with his prescribed medication regime are recorded in his OMH record.

150. In December 2000, a month after the medication orders were discontinued, I.J. began to smear feces in his cell and became very agitated.

151. On December 6, 2000, I.J. refused to leave his cell to be transferred to an observation cell in the OMH Satellite Mental Health Unit. He was forcibly extracted from his SHU cell by DOCS staff utilizing a form of tear gas and an extraction team. After the extraction he was placed in an observation cell in the OMH Satellite Mental Health Unit.

152. Just two days later, on December 8, 2000, I.J. was returned to isolated confinement in SHU. In SHU, he deteriorated to the point where he refused to shower, refused to turn his light on, was paranoid, delusional, fearful and suspicious, and believed others to be possessed.

153. On January 4, 2001, I.J. finally was removed from SHU due to his beliefs that his food was being poisoned and that others were possessed, and due to his refusal to bathe. He was again taken to an observation cell in the OMH Satellite Mental Health Unit.

154. On January 10, 2001, I.J. was committed to CNYPC after remaining in an observation cell for six days where he continued to express paranoid beliefs and suspicions.

155. There is no indication in I.J.'s OMH records from June 2000 through January 2001 that I.J. was ever evaluated for psychiatric hospitalization prior to January 8, 2001.

156. On March 23, 2001, I.J. was discharged from CNYPC to the SHU at Clinton C.F. His discharge plan included a combination of medications, and an indication that he "will need observation, counseling and encouragement to take medications."

157. I.J. was not seen in SHU by OMH staff between April 10, 2001 and May 1, 2001. On May 1, he was observed to be paranoid, and he stated that he did not feel well and that he felt confused. He informed OMH staff that he had stopped taking his medications two weeks earlier.

158. OMH did not take any action to remove I.J. from SHU; he was not transferred to an observation cell in the OMH Satellite Mental Health Unit. He was in fact not seen by OMH staff again for two weeks. At that time, it was noted that his paranoia had increased; he reported that he believed that corrections officers were tampering with his food. The response of OMH staff was to discontinue all of his medications because he had not taken them, and to permit DOCS to continue to house him in SHU. Despite his noted deteriorating mental condition, mental health visits were reduced to a monthly basis.

159. By June 2001, I.J.'s mental status had further deteriorated. He was loud and disruptive and had begun to throw feces around his cell. His behavior resulted in disciplinary charges.

160. OMH mental health staff reported their view that I.J. was "manipulative" and they arranged for his transfer to the Attica C.F. SHU. OMH staff did not arrange for more intensive mental health treatment, nor did they consult with CNYPC.

161. On June 20, 2001, I.J. was transferred to Attica C.F. in an agitated and paranoid state. He refused to comply with a strip search at Clinton C.F. during the transfer procedure and was given an additional disciplinary ticket for this behavior.

162. I.J. was sentenced to two years of SHU time and 18 months loss of good time for refusing the strip search and he received six months of SHU time for throwing feces and urine at an officer.

163. At the Attica C.F. SHU, I.J. has continued to receive tickets for hostile and agitated behavior, and now faces nearly six years of SHU with no appreciable mental health treatment for his schizophrenia.

164. On September 19, 2001, plaintiff DAI notified defendants by letter of its concern that I.J. had not received necessary mental health treatment at Great Meadow, Clinton and now Attica Correctional Facilities, and that he received only harsh punishment for the agitated behavior that resulted from his untreated psychiatric illness.

165. On November 28, 2001, H.E. Smith, the Executive Director of CNYPC, responded that through psychiatric treatment, I.J.'s condition had improved since he had been housed at Attica C.F. However, Mr. Smith offered no response to plaintiff's request for quality assurance and training at Great Meadow and Clinton Correctional Facilities, and to plaintiff's knowledge, defendants have taken no corrective action to resolve the deficiencies identified at those facilities.

166. I.J. is scheduled to remain in SHU through July 2006 - a date more than a year beyond the maximum expiration date of his sentence.

167. On May 16, 2002, I.J. was transferred from the Attica SHU to CNYPC.

Prisoner K.L.

168. K.L. has been a New York state prisoner since 1997. On January 8, 2001, K.L. was transferred to the double-bunk SHU at Upstate C.F. Upon admission to Upstate he was evaluated by an OMH staff psychologist. The screening evaluation noted that he was an active patient on the OMH caseload for the past two years, that he had a history of paranoia and assaultiveness, and that he had been admitted to CNYPC on one occasion after seriously injuring another prisoner in an episode of paranoia. K.L.'s diagnosis as stated in the evaluation is chronic paranoid schizophrenia.

169. The OMH staff psychologist further indicated in the evaluation that K.L. declined mental health services, that no evidence of schizophrenia was present, and that K.L. would not be admitted to the OMH caseload at Upstate C.F.

170. On January 9, 2001, one day after his evaluation, K.L. was seen cell-side by a social worker in response to a letter from K.L. and a DOCS nursing referral. The social worker observed that K.L.'s speech was "mildly illogical" with a "loose pattern" and that K.L. firmly believed that he had a transmitter fixed in the back of his head which gave him special powers. The social worker noted that K.L. had previously been diagnosed with delusional disorder and psychosis. The social worker determined that K.L. was not a danger to himself and was not interested in mental health services. He was transferred to a single-cell SHU at Upstate C.F. to be monitored "as needed." He was not transferred to a facility that has an OMH Satellite Mental Health Unit.

171. On February 1, 2001, K.L. was seen at his cell on routine rounds and was noted to have become increasingly agitated, suspicious and paranoid. K.L. continued to claim that he had a transmitter in the back of his neck, that his birthdate gave him special powers, and that the corrections officers were telling other prisoners that K.L. is in the CIA. The psychologist also noted that he had a history of becoming assaultive when he mentally decompensates, and that he had not eaten in three days.

172. On February 2, 2001, K.L. was transferred to the OMH Satellite Mental Health Unit at Clinton C.F. for observation and evaluation and possible admission to CNYPC. A social worker observed that K.L. was extremely delusional and grandiose. He was claiming to be full of top secret information which he could not disclose lest he be killed and that he had a computer chip installed in the back of his head, which he wanted removed.

173. Stripped to his undershorts and wearing only a paper gown, K.L. was confined to an observation cell for the following twelve days. K.L. endured uncomfortably cold temperatures in the observation cell.

174. K.L. was not seen by a psychiatrist until February 5, three days after his admission to the OMH Satellite Mental Health Unit at Clinton C.F. The psychiatrist noted that K.L. was "acutely psychotic, paranoid and grandiose." The psychiatrist indicated that the treatment plan would be to begin treating him with Haldol and Cogentin.

175. K.L. refused medication on February 6 and continued to speak irrationally. He was reported to be paranoid, suspicious and refusing to eat because he did not trust the food.

176. In the morning of February 7, K.L. continued to speak illogically and continued to deny his need for medication. K.L. stated, however, that he needed to go to Marcy Hospital [CNYPC] because it was unsafe for him to go into general population.

177. On February 8, 2001, the social worker noted that K.L. would be transferred to CNYPC on February 13, 2001. The social worker noted that K.L. continued to express delusions about working for the CIA, and that he was suspicious of staff who prevented him from "carrying out his assignment."

178. K.L. remained in an observation cell for the following five days, becoming angry, demanding and threatening. His thoughts were noted to be incoherent, illogical, and delusional. On February 12, 2001, an OMH social worker noted that his thought process "continues to focus on delusion of persecution" and on K.L.'s need to get somewhere "safe."

179. Finally, on February 13, 2001, after spending twelve days in an observation cell in an acutely psychotic state, K.L. was transferred to CNYPC for stabilization.

<u>Prisoner M.N.</u>

180. M.N., currently age 25, was incarcerated in 1995 to serve a term of 3 1/3 to 10 years for two counts of criminal possession of a controlled substance.

181. Upon arrival in DOCS custody, M.N. had a physical and mental history which included lead poisoning at age 4, mental retardation and childhood behavioral problems. Notations in the OMH records indicate that M.N. also had a history of head trauma requiring surgery in 1982 to put a metal plate in his head. OMH records are devoid of specifics or independent verification of the head trauma and surgery. In 1988, he was diagnosed with conduct disorder, undifferentiated type.

182. During M.N.'s incarceration, he was diagnosed with delusional disorder and antisocial personality disorder.

183. While in prison, M.N. has frequently received misbehavior reports and has been punished with keeplock and SHU time for behavior that is symptomatic of his mental illness.

184. M.N. was committed to CNYPC in July 1998 from Elmira C.F. On arrival at CNYPC, he was paranoid and delusional. He was disheveled, his speech was slurred, and his thought processes were at times illogical. He denied that he had ever been incarcerated and asserted that he was being illegally confined.

185. During his commitment at CNYPC he was periodically restrained due to attempted assaults on staff. He was retained at CNYPC for approximately two months and then discharged to DOCS with recommendations that he be monitored by mental health staff and receive medication.

186. Within approximately one month of M.N.'s return to prison from CNYPC, he began another cycle of keeplock confinement as a result of being found to have violated prison rules. M.N.'s behavior problems continued, and in October, 1999, resulted in a penalty of twenty-four months SHU time.

187. While in the SHU at Sing Sing C.F., M.N. began to psychiatrically deteriorate. In November 2000, he was reported to be disheveled and unclean. His hygiene was poor, his food and fluid intake was decreased, he had altered thought processes and he was nonverbal. On November 28, 2000, due to his obvious psychiatric decompensation, M.N. was transferred from SHU to an observation cell in the RCTP in the OMH Satellite Mental Health Unit.

188. After being held in an observation cell for nine days, on December 7, 2000, OMH determined that M.N. had improved enough to be returned to twenty-three hour isolated confinement in SHU.

189. After transferring him back to SHU, OMH did not have any contact with M.N. for seven weeks. On January 30, 2001, M.N. was seen by OMH staff at cell-side in SHU. OMH reported that M.N. had a chronic thought disorder, was refusing to shower and was only minimally verbal. M.N. was next seen by OMH staff on February 9, 2001, at another cell-side visit in SHU. He was reported by OMH to be distracted and responding to internal stimuli.

190. On March 6, 2001, OMH staff saw M.N. again during SHU rounds. At this time, M.N. was observed with his head covered with a blanket and he would not give verbal responses. OMH noted that an admission to CNYPC to be medicated over his objection might be necessary if his functional status deteriorated to the point that he was dangerous to himself.

191. M.N. continued to psychiatrically deteriorate in SHU. OMH reported that he was internally preoccupied with decreased responsiveness and poor personal hygiene.

192. On May 1, 2001, M.N. was again transferred from SHU to an observation cell in the RCTP at the Sing Sing C.F. OMH Satellite Mental Health Unit. He was nonverbal, unresponsive, was not sleeping or eating, and had poor hygiene. He reportedly had lost contact with reality and had

not taken his medication for months. While in the RCTP, M.N. started voluntarily taking medication, eating and showering.

193. On May 17, 2001, OMH discharged M.N. from the RCTP back to twenty-three hour solitary confinement in the Sing Sing C.F. SHU.

194. On June 12, 2001, M.N. was re-admitted to the RCTP for a forty eight hour observation period and to be medicated by injection. After forty-eight hours, M.N. was returned to SHU.

195. Staff from plaintiff's counsel, Prisoners' Legal Services of New York ("PLS"), conducted a legal visit with M.N. on June 21, 2001, in the Sing Sing C.F. SHU. PLS staff noted a significant deterioration in M.N.'s physical appearance since their previous visit of May 17, 2001. M.N. was dirty, had dried food all over his clothing and reeked of body odor and urine. In addition, M.N. had shaved the hair off of various parts of his body including his eyebrows, arms and legs. PLS staff reported M.N.'s condition to OMH Satellite Mental Health Unit Chief David Boyd by telephone on June 21, 2001. PLS then confirmed this information in a letter to David Boyd dated June 25, 2001.

196. On July 9, 2001, M.N. was again re-admitted to the RCTP for medication by injection. On July 11, 2001, M.N. was returned to SHU.

197. M.N. continues to follow a pattern of being housed in SHU, significantly decompensating, being transferred to the OMH Satellite Mental Health Unit for brief periods primarily for the administration of long term stabilizing medication, and then being returned to isolated confinement in SHU. No other psychiatric services have been made available to M.N. to prevent his continual psychiatric deterioration in SHU.

198. M.N. continues to be housed in the Sing Sing C.F. SHU at this time.

Prisoner O.P.

199. O.P., currently age 23, was incarcerated in November 1999 to serve a term of two to six years for criminal sale of a controlled substance. O.P. has an extensive mental health history that began prior to his incarceration.

200. In January 1996, at the age of 16, O.P. had a series of psychiatric inpatient admissions with diagnoses of psychotic disorder, bipolar disorder and organic psychosis. In addition, O.P. received outpatient mental health treatment from October 1996 through August 1999.

201. While in prison, O.P. has carried a variety of diagnoses including schizophrenia, antisocial personality disorder, mild mental retardation (with a verbal I.Q. of 61) and a learning disorder.

202. O.P. has continually received misbehavior reports in prison due to his inability to conform to prison rules and regulations. As a result of these misbehavior reports, O.P. has spent large amounts of time in keeplock and SHU confinement.

203. O.P.'s first misbehavior report was the result of an incident that occurred on November 14, 1999, just 13 days after his arrival in DOCS custody at Downstate C.F. He was charged with creating a disturbance, the failure to follow a direct order and disorderly conduct.

204. In November 1999, within weeks of O.P.'s arrival at Downstate C.F., he was referred by DOCS to OMH for evaluation. His behavior was noted by DOCS staff to include poor impulse control and an inability to sit still.

205. Approximately one month later, in December 1999, Downstate C.F. again referred O.P. to OMH. This time DOCS staff reported that he was refusing to shower or clean his cell and that he reeked of urine. He was in keeplock at the time.

206. In February 2000, DOCS staff referred O.P. to OMH a third time. DOCS reported that O.P. was pacing in his keeplock cell, yelling and screaming, standing on top of his sink singing loudly and that he did not bathe.

207. On or about March 1, 2000, O.P. was transferred from Downstate C.F. to Sullivan C.F. On or about March 11, 2000, an OMH referral was made by DOCS noting O.P.'s loudness and "darting around his cell." O.P. was still being held in keeplock.

208. On or about March 12, 2000, O.P. was transferred to an observation cell in the OMH Satellite Mental Health Unit. His behavior was reportedly bizarre and he exhibited poor insight.

209. On April 6, 2000, O.P. was committed to CNYPC. He reportedly was agitated, unable to sleep, had poor insight and judgment and was having periods of confusion. His diagnosis at the time of referral included psychotic disorder and he was receiving a number of psychiatric medications.

210. During his commitment to CNYPC, O.P. was placed in physical restraints on several occasions.

211. On May 31, 2000, he was discharged from CNYPC back to Sullivan C.F. By the time of his discharge, CNYPC had altered his diagnosis. The psychotic disorder was deleted and the disorder of antisocial personality disorder was added. However, O.P.'s discharge plan from CNYPC called for periodic mental health contact and continued supportive mental health interaction.

212. O.P. was admitted to the OMH Satellite Mental Health Unit RCTP upon his return to Sullivan C.F. On June 7, 2000, while he was still housed in the RCTP, a disciplinary hearing was held for an incident that took place on April 1, 2000, five days before O.P. was psychiatrically committed to CNYPC. O.P. received a penalty of keeplock time as a result of the disciplinary hearing.

213. O.P. remained in the RCTP until June 19, 2000 when he was released to a cell on keeplock status. During his time in the RCTP he was reported to be easily agitated, his mood was unpredictable and he had periods of screaming and yelling.

214. On June 22, 2000, another disciplinary hearing was held for O.P. This hearing was based on an incident which had occurred on March 29, 2000, seven days before O.P. was psychiatrically committed to CNYPC. O.P. received an additional penalty of keeplock time as a result of this hearing.

215. On July 1, 2000, and July 2, 2000, O.P. was referred by DOCS staff at Sullivan C.F. to OMH staff for evaluation. He was described as standing at his cell gate and screaming throughout the night. He was also described as slamming his head into walls and his fist into his locker for no reason. He was reported not to comprehend his keeplock status or much of anything else.

216. OMH staff did not see O.P. in response to these two referrals until July 10, 2000.

217. On July 17, 2000, O.P. again was admitted to the RCTP for observation as a result of his psychiatric decompensation in keeplock. OMH noted that he was unable to control his behavior and that there was a potential for violence towards others. On or about August 2, 2000, O.P. was returned to his cell in the block and keeplock was resumed.

218. On August 4, 2000, O.P. again was re-admitted to the RCTP at Sullivan C.F. due to his "manic behavior." OMH and DOCS reported that he was yelling, being disruptive and that his thought content was delusional, obsessed and preoccupied.

219. As a result of additional disciplinary proceedings, when O.P. was discharged from the RCTP on August 14, 2000, he was transferred to SHU.

220. On September 12, 2000, O.P. again was admitted to the RCTP for observation as a result of his acting-out behavior. He was loud, his hygiene was poor with foul body odor, and he was fearful and suspicious. OMH staff noted that he had poor impulse control due to limited intellect and that as a result there was potential for violence directed at others. Recommendations by OMH staff included that he be placed in a safe environment, and that coping skills and medication compliance be encouraged. However, OMH permitted his transfer back to twenty-three hour isolated confinement in SHU.

221. On October 17, 2000, O.P. was again admitted to the RCTP because he was psychiatrically decompensating and refusing medication. His hygiene was poor and he was unable to control his behavior. O.P. reported to OMH that he could no longer tolerate SHU confinement. He was admitted to RCTP to help him cope with SHU time.

222. On October 26, 2000, OMH recommended that O.P. be placed in a highly structured environment. Later that month he again was returned to SHU.

223. In November 2000, O.P. was again admitted to the RCTP. OMH staff noted that he was not medication compliant and that as a result his medication had been discontinued.

224. Throughout the period following his release from CNYPC in May, 2000, O.P. continued to receive misbehavior reports and accrue SHU and keeplock time.

225. On or about January 26, 2001, Sullivan C.F.'s Deputy Superintendent Decker scheduled a case conference regarding O.P. Deputy Superintendent Decker stated, "I am seeking to establish a plan of action to eventually remove this inmate from the Special Housing Unit and place him in a proper locking location that will more suitably address his mental health needs."

226. On February 2, 2001, the case conference was held at Sullivan C.F. Present at the conference were DOCS and OMH staff. It was determined that further disciplinary action would be of no benefit to O.P. and that he needed to receive more programming in a heavily structured setting due to his impulsive behavior. It was decided that DOCS would submit a request that O.P. be transferred in the future to a setting where additional mental health services are available.

227. Despite the decision made at the case conference, O.P. remained housed in the Sullivan C.F. SHU, continued to receive misbehavior reports, was found guilty at disciplinary hearings and continued to accrue significant SHU time.

228. On May 19, 2001, O.P. attempted suicide by making a noose and attaching it to a ceiling grate in his cell. O.P. was admitted to the RCTP on that date and it was noted that he had decompensated and had a foul body odor. He was placed on a one-to-one suicide watch. OMH determined that O.P. needed a respite from SHU.

229. On or about May 30, 2001, OMH discharged O.P. from the RCTP and returned him to SHU.

230. On information and belief, on or about June 28, 2001, O.P. was transferred to Great Meadow C.F. where he remains in SHU confinement.

231. Despite defendants' recognition of O.P.'s mental health needs, and despite their decision that his condition necessitated his removal from SHU, O.P. has not been removed from the harsh conditions of isolated SHU confinement and he has not been transferred to a structured therapeutic mental health program.

Prisoner R.S.

232. In August 1998, R.S., currently age 24, was incarcerated to serve a term of four to eight years for two counts of attempted assault and attempted criminal sale of a controlled substance.

233. When R.S. was transferred to DOCS custody he had a lengthy history of psychosis and a prior suicide attempt by hanging. R.S.'s history and his suicide attempt were known to OMH.

234. OMH records note that R.S. was first committed to psychiatric hospitalization while awaiting trial at Rikers Island. He was held incompetent to stand trial and was sent to Mid-Hudson Psychiatric Center where he remained from June, 1997 to April, 1998.

235. During his commitment to Mid-Hudson Psychiatric facility, R.S. was given a diagnosis of antisocial personality disorder and was determined to have a history of attention deficit hyperactivity disorder.

236. In April 1998, R.S. was deemed competent to stand trial, and was subsequently convicted.

237. Within the first month after his transfer to DOCS custody, while at Downstate C.F., R.S. began receiving disciplinary tickets for his behavior. R.S. has now accrued SHU and keeplock time which extends well past the September 2004 maximum expiration date of his sentence.

238. As a result of the inability to assign additional SHU time, other disciplinary penalties were imposed on R.S., including a "restricted diet." The DOCS restricted diet consists primarily of a fortified loaf of bread and raw cabbage. R.S. was on the restricted diet for many months beginning in March 2000.

239. In December 1998, at Downstate C.F., R.S. was put on a suicide watch in an observation cell in the OMH Satellite Mental Health Unit after stating that he was going to hang

himself. Two days later, R.S. was transferred back to SHU to continue serving isolated disciplinary confinement time.

240. In January 1999, R.S. was prescribed the antipsychotic Risperdal.

241. In February 1999, R.S. was transferred to Attica C.F.

242. On February 23, 1999, the prescription for Risperdal was discontinued by OMH staff who reported that R.S. had no major depression.

243. On March 12, 1999, OMH staff determined that R.S. suffered from only antisocial personality disorder. On the basis of this diagnosis they removed him from the OMH active patient list altogether.

244. On or about March 12, 1999, R.S. was transferred to Clinton C.F.

245. On April 19, 1999, R.S. advised Clinton C.F. OMH staff that he was fearful due to a gang-related matter. OMH staff concluded that there was no mental health issue based on this statement although, at the same time, they listed R.S.'s diagnosis as psychosis. OMH staff told R.S. to talk to DOCS staff about his gang-related concerns.

246. On May 30, 1999, while at Clinton C.F., R.S. received disciplinary charges for unhygienic acts, self-harm, assault on an inmate and possession of a weapon. He received eighteen months of SHU time for these disciplinary infractions.

247. In July, 1999, R.S. was transferred to Southport C.F. to continue serving his SHU sentence. Despite his well known and lengthy history of serious mental illness and repeated deterioration in SHU, R.S. was sent to Southport C.F., one of the two maximum security DOCS prisons which does not have an OMH Satellite Mental Health Unit.

248. On July 29, 1999, OMH staff screened R.S. at Southport C.F. and concluded that he had no mental health diagnosis and no treatment needs. On or about March 13, 2000, and May 31, 2000, OMH staff again screened R.S. and concluded that R.S. had no mental health diagnosis.

249. On July 24, 2000, R.S. reported taking an overdose of the antihistamine Sudafed. As Southport C.F. does not have an OMH Satellite Mental Health Unit, R.S. was transferred to an observation cell in the Elmira C.F. OMH Satellite Mental Health Unit. While in the observation cell he smeared himself and the cell with his feces and continued to threaten self-harm. OMH staff diagnosed R.S. with antisocial personality disorder.

250. While in the Elmira C.F. OMH Satellite Mental Health Unit, R.S. was put on antipsychotic medication due to his threats of self-harm, threats of harm to others and behavior of banging and yelling. On July 29, 2000, his diagnosis was changed to add adjustment disorder with mixed disturbance of emotions. OMH staff recommended that R.S. be followed as an active OMH patient expecting R.S. to "act out manipulatively through his behavior."

251. In early August 2000, R.S. was transferred back to the Southport C.F. SHU with a behavior management plan devised by OMH to be used at Southport C.F. if R.S. threatened suicide. Pursuant to the plan, DOCS security staff were to remove items with which self-harm could be attempted. If the incident occurred during normal working hours, R.S. would be evaluated by OMH staff. If the incident occurred after normal working hours, R.S. would be evaluated by OMH staff when they were next on-site at Southport C.F. The plan lacked any provisions for R.S. to be psychiatrically evaluated or counseled, if he became suicidal outside of "normal working hours."

252. In November 2000, during cell-side rounds in the Southport C.F. SHU, OMH staff observed R.S. making vague threats of self-harm. OMH reported their belief that the threats were made in hopes of being transferred out of Southport C.F. and that R.S.'s behavior was manipulative.

253. OMH's response to R.S.'s threats of self-harm was to arrange for a psychiatric evaluation for the stated purpose of terminating him from mental health services. On November 25, 2000, R.S. refused to come out of his cell to be evaluated by the OMH psychiatrist who came to conduct the evaluation. OMH then terminated R.S. from OMH services on November 29, 2000, giving the reason that R.S. was "manipulative."

254. R.S.'s condition immediately declined after OMH services were terminated. R.S. received additional misbehavior reports for incidents that occurred on or about December 1, December 4, and December 5, 2000. He was found guilty of various charges which included unhygienic acts, obstructing visibility into the cell, false alarm, and verbal threats. R.S. received restricted diet penalties for these incidents.

255. On December 6, 2000, R.S. was found unclean in his SHU cell, with feces smeared all over his cell window. R.S. refused to leave his cell and upon the order of Superintendent McGinnis was extracted from his cell by a team of corrections officers for the purposes of showering him and cleaning his cell. After the cell was cleaned and R.S. was showered, he was returned to the same SHU cell and stripped of all possessions, bedding, and clothing other than his underwear and two suicide prevention mats. R.S. received additional disciplinary charges for his behavior including the charge of committing an "unhygienic act."

256. A disciplinary hearing held on or about December 12, 2000, resulted in a finding of guilt with an additional penalty of restricted diet.

257. R.S. has continued to accrue disciplinary charges and restricted diet penalties since the December 6, 2000 incident. DOCS continued to house R.S. in SHU confinement at Southport C.F.

258. On or about July 23, 2001, PLS staff conducted a legal visit with R.S. at Southport C.F. R.S. presented as extremely paranoid and fearful. He reported visual and auditory hallucinations, stating that he saw bugs crawling on his walls and on his body, and that he was hearing voices. He reported feeling hopeless and suicidal. His physical appearance was disheveled and unclean.

259. On or about July 24, 2001, PLS staff wrote a letter to Superintendent McGinnis at Southport C.F. and Peter Russell, OMH Satellite Mental Health Unit Chief for the Elmira C.F., requesting that R.S. be transferred to another facility where his mental health needs could be addressed.

260. On or about August 10, 2001, Peter Russell, OMH Satellite Mental Health Unit Chief for the Elmira C.F. responded to the PLS letter by reporting that R.S. was evaluated after receipt of the July 24, 2001 letter and did not need enhanced mental health services at that time. The response further stated that since that evaluation, however, R.S.'s condition had changed and that he was transferred to a prison with an OMH Satellite Mental Health Unit so additional services could be provided.

261. On or about August 29, 2001, DOCS Deputy Commissioner and Counsel, Anthony Annucci, responded to the PLS letter stating that OMH clinical staff at Southport C.F. evaluated R.S.'s mental health condition after receiving the PLS letter. It was the opinion of the OMH staff that R.S. was "feigning mental illness symptoms in order to elicit sympathy and assistance in obtaining a transfer out of Southport C.F." The letter further stated that subsequent to that evaluation, however, R.S. had made another attempt at self-harm and for that reason, DOCS transferred him to Clinton C.F. which has an OMH Satellite Mental Health Unit.

262. On information and belief, at present, R.S. is housed at Wende C.F. in SHU.

Failure of DOCS and OMH to Establish Adequate Mental Health Programs

263. Despite their legal obligation to do so, defendants have systematically failed and refused to provide medically necessary mental health care to prisoners with mental illness, including but not limited to, necessary and adequate inpatient hospitalization when needed, and necessary and adequate intermediate level mental health care within the prison.

264. As a result of defendants' practices, policies and procedures, prisoners with mental illness, based on the symptoms of their disabilities, have been, and continue to be, excluded from participation in, or denied the benefits of medically necessary mental health services.

265. Despite knowledge from ongoing litigation that they have provided inadequate mental health care for prisoners with mental illness housed in twenty-three hour isolated confinement, DOCS and OMH have failed to enhance such services. In fact, defendants have increased the number and variety of restrictive twenty-three hour isolated confinement housing facilities.

266. There has been no comparable expansion of mental health staffing levels even though twenty-three hour isolated confinement is known to exacerbate mental illnesses and to make the prisoners' need for care more urgent.

267. Prisoners with mental illness are housed and suffering from their illnesses in twenty-three hour isolated confinement housing areas where they are either serving disciplinary sentences or are held as administrative segregation status prisoners.

268. Defendants have long been aware of the gross deficiencies in their delivery of mental health treatment to prisoners but have failed to remedy these known deficiencies. The SCOC has repeatedly notified OMH and DOCS of their findings of inadequate mental health policies and procedures in New York State prisons, and has cited inadequate resources to manage long-term

treatment for prisoners with chronic and persistent mental illnesses as a factor in suicides in past years. Despite such notice provided by SCOC, ongoing litigation, which has resulted in consent decrees and damage awards for prisoners pertaining to mental health treatment at various prisons, and other evidence of deficiencies in caring for prisoners with mental illness, defendants have failed to provide adequate mental health care to treat prisoners' serious mental health needs on a system-wide basis.

FIRST CAUSE OF ACTION

Cruel and Unusual Punishment in Violation of the Eighth and Fourteenth Amendments to the United States Constitution

269. By their policies, practices and acts, defendants violate the rights of prisoners with mental illness to be free from cruel and unusual punishment as guaranteed by the Eighth and Fourteenth Amendments to the United States Constitution.

270. As a matter of policy and practice, defendants, with deliberate indifference, fail to provide prisoners with mental illness with adequate mental health treatment and therapeutic housing options necessary to treat and to prevent worsening of their mental illness.

271. As a matter of policy and practice, and with deliberate indifference to their mental health needs, defendants impose periods of prolonged isolated confinement upon prisoners with mental illness which lead to the deterioration of their mental health.

272. By imposing periods of prolonged isolated confinement without regard to the deleterious effect that it will have on prisoners' mental health, defendants act with deliberate indifference to the substantial risk of serious harm to prisoners with mental illness.

SECOND CAUSE OF ACTION

Violations of the Americans with Disabilities Act (ADA) and of Section 504 of the Rehabilitation Act (Section 504)

273. Plaintiff's constituents are qualified individuals with disabilities as defined in the ADA and in Section 504. They have mental impairments that substantially limit one or more major life activity, including but not limited to thinking, concentrating, and interacting with others; they have records of having such an impairment; or they are regarded as having such an impairment. As state prisoners, all plaintiff's constituents meet the essential eligibility requirements for the receipt of services or the participation in programs or activities provided by defendants DOCS and OMH. 42 U.S.C. §12102(2); 42 U.S.C. § 12131 (2); 29 U.S.C. § 794.

274. Defendants DOCS and OMH are public entities as defined under 42 U.S.C. § 12131(1)(B).

275. DOCS and OMH receive federal financial assistance.

276. Defendants discriminate against mentally disabled prisoners by failing to provide alternative punishments as a reasonable accommodation so that punishments which exacerbate mental illness are not imposed.

277. Defendants discriminate against mentally disabled prisoners solely on the basis of their disabilities in violation of Section 504 and on the basis of their disabilities in violation of the ADA. 29 U.S.C. §794; 42 U.S.C. §12132.

Prayer for Relief

278. Prisoners have suffered and will continue to suffer irreparable injury as a result of the unlawful acts, omissions, policies, and practices of the Defendants as alleged herein, unless they are granted the system-wide relief they request. This complaint seeks systemic system-wide relief and does not seek to duplicate or supplant relief, either court ordered or by settlement, sought in any prior case litigated on an institutional basis.

279. Wherefore, plaintiffs request that this Court grant them the following relief:

a. adjudge and declare that the acts, omissions, policies, and practices of the Defendants with regard to Prisoners violate the Eighth and Fourteenth Amendments to the United States Constitution; the Rehabilitation Act, 29 U.S.C. § 794; and the Americans with Disabilities Act of 1990, 42 U.S.C. § 12132;

b. enjoin Defendants, their agents, officials, employees, and all persons acting in concert with them, under color of State law or otherwise, from continuing the unconstitutional and illegal acts, conditions, and practices described in this Complaint;

c. appoint an independent mental health professional to assess the treatment and housing needs of prisoners with mental illness and who is authorized to preclude placement of prisoners with mental illness into isolated confinement housing areas;

d. order Defendants, their agents, officials, employees, and all persons acting in concert with them, under color of State law or otherwise, to take all necessary actions to:

i. create sufficient hospital bedspace to provide short-term and long-term inpatient treatment for prisoners with mental illness in need of inpatient care;

ii. provide sufficient mental health treatment programs and services to prisoners with mental illness in state correctional facilities including expanded intermediate residential mental health services housing and other alternative housing so that prisoners with mental illness are not housed in 23 hour confinement housing areas or other counter-therapeutic settings;

iii. provide increased and sufficient staffing to provide adequate mental health screening, monitoring and treatment within DOCS facilities and at CNYPC;

iv. create patient tracking mechanisms so that OMH is notified of, or knows of, predictable stressful events when they occur to prisoners with mental illness (i.e. assaults, sentencings, losses of job, illnesses, arrests, disciplinary tickets, disciplinary sentences, psychiatric discharges);

v. teach DOCS staff during pre-service and in-service training programs to recognize the signs and symptoms of mental illness and to prevent suicides;

vi. provide advanced training to DOCS staff assigned to medical, mental health and high risk settings, including disciplinary detention and administrative segregation facilities, in suicide prevention and in the management of prisoners with mental illness;

280. award plaintiffs costs and disbursements of this action including reasonable attorney's fees; and

281. grant such other and further relief as this Court deems just and proper.

Dated: New York, New York
May 28, 2002

Respectfully submitted,

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