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1. *REPORT OF STUART GRASSIAN, M.D., 2001 Misc. Filings LEXIS 627*

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REPORT OF STUART GRASSIAN, M.D., 2001 Misc. Filings LEXIS 627

United States District Court for the Northern District of Ohio, Eastern Division

Case No. 4:01-CV-071

November 4, 2001

Reporter
2001 Misc. Filings LEXIS 627 *

Charles E. Austin; et al. v. Reginald Wilkinson; et al.

Expert Name: Dr. ***STUART*** EDWIN ***GRASSIAN***, M.D.

Text

Austin v. Wilkinson.

Anticipated Testimony of ***Stuart Grassian***, M.D.

My name is ***Stuart Grassian***, M.D. I am a Board-certified psychiatrist, licensed to practice medicine in the Commonwealth of Massachusetts, and subspecialty-certified in Forensic Psychiatry. I have had extensive experience in evaluating inmates housed in special housing units, including at supermax facilities similar to the facility at OSP. My experience with the effects of such confinement generally includes involvement in a number of federal and state class-action lawsuits regarding such conditions, most recently including work on behalf of the Florida Department of Corrections in settling a class-action lawsuit brought on behalf of inmates confined in Close Management in the State of Florida. My observations and conclusions have been cited in a number of federal court decisions, for example: *Davenport v. DeRobertis, 844 F.2d 1310,* and *Madrid v. Gomez. 889 F.Supp 1146.* A copy of my curriculum vitae, and a list of cases in which I have testified during the last five years, is attached.

I prepared a written declaration **[*2]** for Madrid describing the medical literature and historical experience concerning the psychiatric effects of solitary confinement and of other conditions of restricted environmental and social stimulation. I subsequently prepared the general (non-institution specific) and non-redacted (non-inmate specific) portions of that declaration into a general Statement, which I entitled "Psychiatric Effects of Solitary Confinement"; this Statement has, in turn, been incorporated into several affidavits which I have prepared concerning these issues, and have submitted to various federal and state courts. A copy of this Statement is attached hereto and forms an integral part of my proposed testimony.

In regard to the present litigation, I had the opportunity to tour the OSP facility on October 9 2001. On October 9 and 10, I interviewed 11 (with inmates, a list of whom is attached. The first two of these our interviews (with) Messrs. Iacovone and Perotti) were conjointly conducted by Dr. James Gilligan, and the rest were conducted individually by myself. The inmates interviewed were not chosen randomly. Instead, they were either inmates who had significant prior correspondence with Attorneys **[*3]** Staughton and Alice Lynd, or they were inmates who were thought by the Lynds or by myself (after reviewing mental health records) to have significant psychiatric difficulties adjusting to the supermax environment.

The physical and administrative conditions prevailing at OSP are in many ways typical of those seen at other supermax facilities and, as indicated in my Statement, are of such stringency as to create significant risk of psychiatric harm. In some measures, however, the conditions at OSP are particularly severe and isolating. There is virtually no contact at all with the outside world, and even the "outdoor recreation area" virtually parodies the term "outdoor". The solid steel doors make communication between prisoners very difficult, and during my tour of the facility, I was struck by the fact that many inmates appeared not to have even been aware of our presence on the

tier. Moreover, the conditions of visitation are especially harsh; despite the fact that the visits are entirely non-contact, the prisoner is required to remain shackled, hands and ankles, and "black boxed" during the entire visit. The situation causes so much physical discomfort, cramped muscles, and **[*4]** psychological stress (the inmate cannot stretch out a cramp, scratch an itch, or even hardly move his muscles at all), that visitation becomes a distressing experience for inmate and visitor alike.

Indeed, inmates describe that any movement from their cells is highly aversive, and several of them reported that they routinely decline exercise yard, and even showers, in order to avoid being cuffed and pushed along roughly by the correctional officers.

In any event, the thrust of my effort in this matter has been to evaluate the mental health situation of inmates at OSP, and the adequacy of mental health response to the psychiatric needs of these inmates. Review of inmate correspondence, mental health records and behavioral observations by correctional staff plays a key role in this process. I am currently still in the process of reviewing mental health charts and other documentation regarding the inmates whom I interviewed as well as others, and some of this documentation has apparently not yet been forwarded from the Ohio Department of Rehabilitation and Corrections (DRC). A list of documents received is attached hereto.

Despite the fact that I have not completed my review **[*5]** of documents in this matter, the information which I have to date reviewed reveals a consistent, systematic pattern of problems with the mental health process of assessment and response at OSP. As I describe in detail in my Statement, conditions such as those at OSP are potentially very toxic to mental functioning, and especially so for those who are psychiatrically vulnerable. As found for example by the Madrid Court, supermax confinement is intrinsically a great psychological punishment, but the imposition of such punishment upon those who are particularly vulnerable is unconscionably cruel.

The stated policy of the DRC gives lip service to this reality, declaring that no seriously mentally ill inmates will be housed at OSP. Indeed, the mental health staff with whom we spoke at OSP give further lip service to this idea - stating that, not only are there no seriously mentally ill inmates at OSP, but that there are no inmates at OSP whom they are even concerned might become seriously ill.

The interviews I conducted, and the records which I reviewed, harshly belie these propositions. Of the eleven inmates whom I interviewed, five (Swofford, Noble, Burke, Hedger, Hoepf) were **[*6]** dramatically ill - to the point where hospitalization would have been a more appropriate response than supermax confinement. The other six suffered to varying extent, but at least two of these (lacavone, Riggins) had serious mental illness. The process of psychiatric evaluation and screening at OSP has been strikingly inadequate, and reflects too great - and too facile - a tendency to find "malingering" and "manipulation" where there is in fact severe illness and suffering.

I anticipate that my testimony will largely consist of detailed descriptions of some of the inmates whose illness is most compelling, and for whom the OSP mental health evaluation and response has been most strikingly inadequate. Rather than presenting my anticipated testimony herein in conclusory form, I shall attempt here to present also the process by which I arrive at those conclusions. I do so by describing in detail my findings regarding one of the inmates whom I interviewed, Eric Swofford. I chose him from the following criteria: 1) he is one of the five most troubled inmates; 2) within this group, he is the first one I encountered. I did not rely upon two other possible criteria: 1) I did not conclude **[*7]** that he was an especially compelling case among the five; 2) I have no reason to think that the attorneys in this case will more likely ask me to testify concerning him than concerning some other inmate.

(As is true for several of the inmates, I have not yet received a copy of Mr. Swofford's full mental health record, and my comments herein may be supplemented when these further records are provided.) Mr. Swofford is a 40 year old mildly retarded man who has spent most of his life institutionalized, and he has been incarcerated continuously since he was 19 years old. He has long-standing learning problems as well as problems with impulse control and hyperactivity; as a child he was in special classes and was prescribed Ritalin for Attention Deficit Hyperactivity Disorder. His family history is positive for serious psychiatric disturbance, involving long-term institutionalization, in two of his four grandparents.

At least as early as 1980, when he was first incarcerated, he was seen as having a serious psychiatric disorder in addition to his mental retardation. In an evaluation on February 18, 1980 he was noted to be:"… suffering from a type of psychosis. He constantly walks **[*8]** back and forth and talks to himself." He had been on antipsychotics even prior to that time, and he continued to be prescribed antipsychotics thereafter. He was also noted to be violent and self-destructive - once attempting to kill another inmate, and several times attempting to set fire to his own cell. Psychiatric evaluation raised the possibility of temporal lobe seizure or dysrhythmic disorder. Psychological testing indicated evidence of mental retardation and of mild organic brain deficit, as well as of bizarre and schizotypal responses. The testing report concluded: "Swofford is a 19-year-old, first offender, whose criminal history has been limited to stealing cars and dealing in stolen property. He has been institutionalized much of his life and has received little needed attention. … In general, the clinical picture is that of an emotionally disturbed, mentally retarded individual who is totally unequipped to cope with prison life. … He is not presently seen as psychotic, but there seems to be a potential for a psychotic break under stress."

Over the subsequent years of Mr. Swofford's incarceration, it appears that little attention has been paid to these observations **[*9]** and concerns, and little mental health treatment has been provided. The record of psychiatric involvement is extremely scant. Instead, his behavioral difficulties were simply responded to by punishment and isolation. In 1991, he did finally receive a psychiatric evaluation at Mansfield Correctional Institution, by Dr. David Tharp. Dr. Tharp noted that Mr. Swofford was suffering from depression, with crying spells and decreased appetite with a 20 pound weight loss during the preceding months. He was also fearful and paranoid, and hyperattentive to external stimulation. Dr. Tharp questioned to what extent Mr. Swofford's confinement in isolation had contributed to these difficulties - he had by then been in segregated confinement for most of the prior seven years.

It appears that nothing was done to follow up on this concern, and eventually, in May 1998, Mr. Swofford was referred for transfer to OSP, the most stringent and isolating of all confinement in the Ohio correctional system. At OSP, the response to Mr. Swofford's mental health issues has been strikingly inadequate.

As is stated in the Ohio DRC's policies and procedures, mental health evaluation should be provided to **[*10]** all inmates transferred to OSP - both at the time of initial referral and periodically thereafter - and especially when the inmate complains of psychiatric distress, or when his behavior suggests psychiatric decompensation. Yet in fact, at OSP the process of assessment of mental health history and status is strikingly and systematically inadequate, so much so as to suggest that the mental health process is more one of filling out paperwork than it is of taking care of patients. Mr. Swofford's record is typical in this regard. Since Mr. Swofford's arrival at OSP in June 1998, there are only two documents in the mental health file I received which could even purport to be attempts at evaluation of his mental health history.

The first of these is the Detailed Mental Health Screening Form (DMHIS) prepared in June 1998 at the time of his referral to OSP. This screening should accomplish a triage function, to indicate whether an inmate requires more thorough psychiatric evaluation or treatment. Yet Mr. Swofford's DMHIS concluded that he needed no further evaluation or treatment. Given his history as presented above, how could this result follow? Only through a process of indifference **[*11]** - of simply filling out a form, rather than raising concern that the individual described in that form could be in distress, or at risk.

Mr. Swofford's completed DMHIS form reveals this indifference. For example, it vaguely (not even accurately) records the fact that he had a history of having been prescribed antipsychotic medication, but provides no elaboration or explanation. Why had such medications been prescribed? What had been their effect? Similarly, the form simply records the fact that he had attempted suicide at least twice previously, but without attempting any inquiry whatsoever as to the circumstances or situation. (Such inquiry would have revealed that he was in segregated housing at the time.) Similarly, the form simply records the fact that he had prior psychiatric treatment including the use of antipsychotic medications, without even attempting to provide detail or explanation of the reasons for this treatment. And lastly, the form simply records the fact that Mr. Swofford expressed worries about his isolation status, without even attempting to explore the nature of those worries, or even commenting upon the fact that the issue of the effects on Mr. Swofford of **[*12]** segregated confinement had been raised previously in a psychiatric evaluation.

The DMHIS form in Mr. Swofford's chart indicates that the evaluator response to this recording of information was one of indifference. No attempt was made to explain or elaborate, or explore the implications for the question of whether it was appropriate for Mr. Swofford to be committed to OSP confinement. Nothing was done except to fill in the boxes, and to endorse - without any reasonable foundation - that Mr. Swofford was eligible for OSP confinement, and did not require any further mental health evaluation or treatment. The triage function was thus performed in a grossly inadequate fashion, and no consideration whatsoever was given to the possibility that OSP confinement might well lead to a deterioration of his psychiatric status.

The record since 1998 reveals that Mr. Swofford's mental health issues continued to be largely ignored over the next three years, with very infrequent contact with mental health staff. Indeed, what contact there was, was apparently quite aversive. It appears that, during the next years, the only non-cell front interviews he had with mental health personnel occurred **[*13]** during the course of yearly reclassification hearings, and the circumstances of these interviews was entirely aversive. In January 2001, Mr. Swofford complained bitterly about the circumstances of a reclassification interview in which a psychologist, Dr. Biggs, had been present: "I was put in immobilizing restraints, legg-irons [sic] and handcuffed behind my back placed into an isolated room behind two locked doors and then actually chain down behind my back with locks & chains to an iron stool. … No human being is immune from such humiliating experience like this, this type of treatment has mental effects on me, and I'm making you aware of it, Dr. Biggs."

Dr. Biggs' response to this complaint was callously dismissive, and failed to even acknowledge that such circumstances of interview were difficult, and not at all conducive to the accomplishment of his own professional task -the development of trust and the disclosure of potentially sensitive psychological information. Dr. Biggs response was only: "Your concern re: the security aspects of your reclassification hearing held on 1-9-01 should be addressed to the prison administration. Mental Health Services does not create **[*14]** policy re: security issues."

Yet Dr. Biggs was under a professional obligation to consider this problem, and not simply to shrug it off as someone else's concern. What if those security policies significantly impaired the ability of the mental health professional to complete his professional responsibility to an inmate? Given how extremely limited is the contact between mental health and the inmates at OSP, is it not critical that what contact does occur, occur in some environment which is at least not intensely aversive for the inmate? Dr. Biggs' reply to Mr. Swofford suggests no concern on his part regarding this issue, no willingness to even empathize with Mr. Swofford's feelings about it.

In May 2001, Mr. Swofford put in a request - and ultimately also a complaint - seeking psychiatric help. He was eventually seen by the psychiatrist, Dr. Bengala. Mr. Swofford explained to Dr. Bengala that over the prior months, he was becoming increasingly fearful. He was fearful that he was having a heart attack. He feared that the guards were plotting against him - poisoning him. He complained that he was very jumpy and could not sleep well. He cited two main stressors - the death **[*15]** of both of his parents as well as his uncle, one year previously, and his difficulty tolerating his conditions of confinement in the supermax facility.

Dr. Bengala's consequent note purports to be a psychiatric evaluation of Mr. Swofford, and concludes with various diagnoses (Unspecified Depression, Generalized Anxiety Disorder, [chronic] paranoid traits) but it reveals no indication at all that Dr. Bengala reviewed prior documents or notes regarding Mr. Swofford; there is no mention of prior (divergent) diagnoses and no attempt at integration of prior assessments with his own. Instead, here and in many other inmate records, it is as though this impression - these "diagnoses" - are just the impression of the moment, something which vaguely fills the paper. And the "Treatment Plan" -"medication and psychotherapy" are entirely generic and non-specific. Indeed, under "next appointment", Dr. Bengala only writes in "Rounds" -that is, something entirely generic, neither private nor individualized.

Apparently, the only practical result of this "evaluation" was that Dr. Bengala then prescribed two medications for Mr. Swofford - an antipsychotic (Risperdal) and a sedating medication **[*16]** for sleep (Sinequan). Not surprisingly, Mr. Swofford's agitation continued unabated. Indeed, he described feeling worse with the medication, because both drugs caused him to become mentally foggy, and less able to respond to his environment and to its perceived threats.

One month later he had an episode of agitation and of hearing voices. A nurse asked that he be seen again by mental health staff, whose triage note reports: "[He] states he kept hearing someone calling his name. He states he kept answering 'What?' and got so upset when it [was] happening that he vomited. … He states he is afraid there is something in the water and is afraid someone put a 'mechanism' in his spigot." He was described as agitated and extremely hypervigilant.

In response to this referral, Dr. Bengala again met with Mr. Swofford. Mr. Swofford told Dr. Bengala that he became more anxious and paranoid when he was alone in his cell: "Doc, it comes and goes. Now I'm O.K. because of talking with you, but when alone I think they are messing with my water and food. I'm concerned they may poison me. Sometimes it makes me so nervous, I vomit and my heart races."

Dr. Bengala apparently simply **[*17]** ignored Mr. Swofford's statement that his conditions of confinement were a significant cause of his mental problems, and nothing more was done - except for ordering an increase in the dose of medications which were already causing Mr. Swofford a problem with side effects. He eventually came to refuse the drugs, and nothing further was done to relieve his condition.

Mr. Swofford's mental suffering continued; it was all too apparent when I interviewed him in October 2001. He was very agitated and fearful, at times stuttering and tremulous, almost unable to speak, his arm and legs shaking, at times violently. He described intense fear: "The pressure keeps chiseling away. I feel helpless. It's real bad. … My nerves-they slam the door real hard. Makes you real jumpy. … I'll be laying in bed and suddenly I jump up and jump to the door and hit it… Jittery inside, start sweating. Extreme confusion, chaotic. I be feeling bad. Over time it became worse - inside me rage, fear building up. Got me on the edge. I'll be hearing stuff - my (deceased) father coming back to me. … I can still hear my father; it's depressing. I worry about having cancer. I feel these people are trying to **[*18]** kill me."

He described little ability to control his fear and the depressing voices, and little ability to distract himself from them: "I can't concentrate that good. That TV don't do much good, but I keep the sound up to block out the slamming (of doors on the tier). I argue with other inmates - the littlest things get me upset. It's hard for me to concentrate to read - I haven't read a book in years. I haven't been out to rec in a month. It's not worth it. You're shackled; they want you to walk at their pace. All I do is pacing, shaking, walking, thinking, thinking… When I first came here I wasn't nervous like this."

Mr. Swofford's case, and others, illustrates systemic difficulties in regard to the psychiatric status of inmates at OSP:

> Psychiatric evaluations are cursory and indifferent, as though the task were more one of filling in a form than of taking care of a patient. There is too great a tendency to view inmates as simply "manipulating" and not truly suffering. (Even with Mr. Swofford, when he was first interviewed in May 2001 and reported that he had previously taken the antipsychotic Thorazine with good effect, the only response of the mental health interviewer **[*19]** was to surmise that he was most likely lying about being in distress, because he was "manipulating" to get medicine. This "conclusion" is rather astonishing, especially given the fact that Thorazine is almost universally disliked by patients, because of its many side effects.)
>
> No real treatment is provided, and even medication - the one treatment truly being offered - is ineffective because it is prescribed without the context of a therapeutic relationship. Without this context, medication compliance will inevitably be very poor.
>
> No real consideration is given to the potentially harmful effects of OSP confinement itself upon the psychiatric status of inmates, even - as in Mr. Swofford's case - inmates who are particularly likely to be incapable of tolerating such stringent conditions. No ameliorative measures are even contemplated.

Signed this 4th day of November, 2001.

[SEE SIGNATURE IN ORIGINAL]

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