SOURCES OF INFORMATION
Saunders

1. Medical Record of Inpatient Psychiatric Admission from 5/23/03 to 9/12/03.
2. Evaluation for Treatment over Objection – the first of Christopher M. Deakin, MD dated 8/29/03 and the second of Igor Kashtan, MD dated 8/18/03
3. 9/11/03 Hospital Forensic Committee Clinical Summary of Igor Kashtan, MD
4. Medical Records of Inpatient Psychiatric Admission to Elmira Psychiatric Center – 4/4/03 to 5/23/03. These records included the Kegomentic Medical Center mental health unit psychiatric evaluation of 4/4/03 – an evaluation for treatment over objection summaries of April Roberts, DO of 4/16/03 and Veena Garyali, MD of 4/22/03.
5. Records contained in the record of admission to the Rochester Regional Forensic Unit from 1/30/98 to 3/31/98. These records include various documents related to the investigation and adjudication of the arson third charge which subsequently resulted in a 3 30 20 plea. Specifically site these separately – the report of psychological evaluation of Norman J. Lesswing, PhD, dated 6/14/97. The next, Paul Povinelli, PhD, dated 6/14/97. An emergency department report of 1/11/97 attributed to Lawrence Sheiman, MD. The next is the "closing" summary of treatment by Amari Meader, CSW reporting on treatment from 5/96 to 1/97.
6. Progress notes of treatment with Amari Meader, CSW from 5/8/96 to 2/6/97. A variety of materials attributed to Kevin Saunders including letters, e-mail, a web-site content. Some of these materials are undated and others are from various periods in 1990 and 1992.
7. Sixty-four pages of records dated from 5/28/93 to 1/31/99. They appear to be clinical records of psychotherapy sessions of an unknown source.
8. The next are records of psychiatric evaluation and treatment at the Elmira Psychiatric Center, Chemung Treatment Clinic from 5/8/02 to 5/27/03.
9. Next are records of the Tompkins County Mental Health Services of Tompkins County Mental Health Center from 6/2/98 to 2/9/99.
10. A discharge summary from admission to the Keuka Medical Center Psychiatric Inpatient Unit from 4/27 to 5/2/02.
11. A CPL of 3 30 20 outpatient quarterly monitoring report of Linda Riley, CSW-R, and John Bezirganian, MD of uncertain date with a fax date of 1/31/02.

Saunders Report
Draft

Last Revised 9/24/03

The following opinions are each offered to the standard of a reasonable degree of medical certainty.

Diagnostic Impressions and Treatment Recommendations:
In my opinion, Mr. Saunders has, at his baseline, a personality disorder that is best characterized as schizotypal personality disorder. Superimposed on this he has had a syndrome of recurrent psychotic episodes that have proven difficult to definitively diagnosis. In my opinion these episodes either represent a Brief Psychotic Disorder (that may be part of the schizotypal personality phenomena), are evidence of Bipolar Disorder, Schizoaffective Disorder, or Schizophrenia.

Based on the history I obtained from Mr. Saunders, the examination that I conducted of him, materials in his record that include information gathered from former employers, intimates and writings attributed to him, writings attributed to him available on the internet, and the history and observations offered by his friend and housemate, I conclude that he has a schizotypal personality disorder.

Individuals with schizotypal personality disorder have many features that are shared with individuals with schizophrenia including eccentricities of appearance, dress, speech (excessive use of metaphorical speech, stilted use of language and words), thought (including magical thinking, persecutory ideas and ideas of reference, superstitions, and other overvalued ideas), and difficulties related well to others. They are often rigid and obsessive in their thinking and compulsive in behavior. They may have brief episodes of psychosis (delusions, hallucinations, disorganized behavior) around periods of stress that are typically self limited or respond rapidly to medication and supportive interventions. Unlike persons with schizophrenia, they do not have extended episodes of psychosis. Based on studies of inheritance, it appears that schizotypal personality disorder is closely related to schizophrenia and may represent a variant expression of the same vulnerability or a continuum of symptoms. Some individuals with schizoptypal personality disorder do go on to develop schizophrenia, but this route is not thought to be common.

Typically, individuals with schizotypal personality do not come to the attention of mental health professionals unless or until something impacts on them to create mood or anxiety symptoms or an outbreak of psychotic symptoms, or they develop a second, cormorbid condition, for example, major depressive disorder. Sometimes a school, employer or loved one will mandate an evaluation to answer questions about why the person is so odd or why he or she is having so much difficulty with interpersonal relationships or role function. Most individuals with the condition are able to function reasonably well as they often adapt by gravitating to interests and occupations that are more solitary and to individuals or groups (e.g. fringe interest, political and religious groups, cults) that share similar interests and that will accept them as they are.

I believe Mr. Saunders life story and the initial reasons for contact with the mental health system is a typical example of the phenomena and natural course of the schizotypal personality. He is a very unusual man in his appearance, identifications, speech and ideas. He finds niches where his intellectual and creative talents have been put to good use and he has enjoyed some successes, but he has also been ostracized and seen as a difficult eccentric which has caused social, and occupational disadvantages. At times he has developed enough distress to seek the help of mental health professionals, and his employer mandated one evaluation that led to a course of psychotherapy treatment.

Superimposed on this baseline condition of schizotypal personality disorder, Mr. Saunders has had three (possibly two as the "third" episode may have been a relapse of the second) episodes of acute psychosis. These episodes have had symptoms and signs that are non-specific which makes definitive diagnosis a challenge. The first episode developed over a period of a few months in 1996, precipitating during a period of interpersonal crisis with his lover. During this time he was in psychotherapy and apparently seen as having significant enough mood and anxiety symptoms and sleep disruption to be prescribed the antidepressants Prozac and Trazodone. He developed a complex persecutory delusional system and increasingly disorganized thought and behavior, mood change and insomnia. In the throes of this psychosis, he exhibited criminal behaviors. These included an accusation of forcing sexual contact on the girlfriend and arson of a trailer home, the later offense committed while he was cross-gender dressed. He was hospitalized briefly and responded rapidly and completely to antipsychotic treatment. Subsequently, he was adjudicated to an NRGI by plea, found not dangerously mentally ill and was returned to the community with conditions and on no medications.

Over the next six years he lived independently in his own home, worked as an independent software developer, cared for his daughter, and did not come to the attention of authorities except when he persistently quibbled about certain conditions of his CPL status and often came to loggerheads with his providers about his refusal to satisfy some of the conditions, for example abstention from alcohol or drug use and submission to urine toxicology screens. He was not treated with medications and it appears that the professionals working with him did not believe medications were clearly necessary. Their notes indicate the impression that he had a brief episode of psychosis that did not fit neatly into a diagnostic category. There was not continuing evidence of psychosis or mood disorder to argue that active or preventative medication treatments were indicated, certainly not a situation in which imposed treatment was necessary.

He next developed signs and symptoms of acute psychosis in April of 2003. After a period of several days of a viral-like syndrome with fever and malaise he became delusional, disorganized and possibly disoriented. He was briefly admitted to a community hospital psychiatric unit, medically evaluated and rapidly cleared with two doses of antipsychotic (Haldol) medication. The attending's discharge summary puzzles about the etiology and comments on the unexpected, rapid, and apparently complete response to antipsychotics. Within several days he again became psychotic with

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symptoms including-----that were more dramatic and persistant than the earlier admission. These symptoms cleared gradually after several initial doses of antipsychotic medication and with the passing of time. He has not demonstrated evidence of acute psychosis for nearly 4 months at the time of this report. He does continue to demonstrate the symptoms and signs of the underlying schizotypal personality disorder, which I believe some have confused with active psychotic symptoms.

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What makes these psychotic episodes difficult to definitively diagnosis is that they do not neatly fit into a syndrome. Some features argue that the syndrome is behaving most like Bipolar Disorder. These include the fact that The first episode was preceeded by depressed mood disturbance, presented during a period of exposure to antidepressant agents, had and insidious onset that began with a depressive mood disturbance and delusional thought and crested with some manic-like qualities. Symptoms cleared cleared rapidly with antipsychotic exposure and did not recur even without maintenance medication treatment until April of 2003. The second episode included some manic-like features (insomnia, irritability, ?other) but did not involve prominent mood change and was characterized with primarily persecutory and bizarre delusions. Again, he cleared rapidly with two doses of antipsychotic medication, but shortly relapsed. The third episode (or relapse of the second episode) again included insomnia, irritability, overactivity, disorganized speech and behavior and bizarre delusions including misidentity, nihilism and the perception of being controlled by an outside force. He also described auditory hallucinations and various somatic preoccupations that were of delusional proportion. This time it took about six weeks for acute symptoms to resolve after the initial use of antipsychotics.

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Some of these findings support the diagnosis of a primary mood syndrome (like Bipolar Disorder), others a primary psychotic disorder (like Schizophreniform Disorder or Schizophrenia) or a mixed syndrome (like Schizoaffective Disorder). It is possible, but less likely in my view, that these episodes represent Brief Psychotic Disorder that may be caused by the underlying Schizotypal Personality Disorder.

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Mr. Saunders has made much of the fact that the first episode occurred in the context of exposure to the antidepressants. He is correct that this exposure may have had some relevance to the "Why now?" of the first episode because the antidepressants may have exposed a vulnerability to mania or to psychosis. Now one can say with confidence that the psychosis is recurrent, and the last two episodes appear to be autonomous. These facts establish that he is likely to experience future psychotic episodes (whatever the cause) and that prophylactic medication ought to reduce the risk of recurrence.

The lack of certainty about diagnosis creates challenges in selecting the correct medication since some of the features of the illness and course would suggest that a mood stabilizer alone might offer good protection (e.g. lithium, valproic acid or carbamazepine). Other features suggest that an antipsychotic medication would provide the best protection against recurrence. The long interval between psychotic episodes one and two makes it difficult to predict when recurrence might next occur and tells us that it may be a long while before the quality of prevention can be assessed. My recommendation is to begin with a either antipsychotic medication or a mood stabilizing medication. I recommend that the choice be determined by what the team feels most confident with and what Mr. Saunders feels most confident with and will most likely to adhere to. It also must be accepted that whatever preventive strategy is used, it could fail despite good compliance with the medication because no strategy can offer completely reliable prophylaxis only a marked reduction in the risk of recurrence.

He has an incidental finding of cannabis use that meets criteria for cannabis abuse, because his pattern of use meets the DSM-IV criteria of "continued substance use despite having persistent or recurrent social or interpersonal problems caused or exacerbated by the effects of the substance (e.g., arguments with spouse about consequences of intoxication, physical fights). (i.e. the hazards of violating his conditions of release on CPL status and conflicts with his treatment teams). It must be acknowledged that the information on which substance use diagnoses is based is his self-report and the report of his housemate. If these data are inaccurate or incomplete, the problem could rise to the level of cannabis dependence. It is my opinion that cannabis use is not the cause of his psychotic episodes, but it may be a contributing factor that increases the vulnerability to psychosis.

You asked me to offer opinions about whether Mr. Saunders has a mental illness, whether he has a dangerous mental illness and whether he is a candidate for treatment over objection as these concepts are defined in New York State Criminal Procedure and Mental Hygiene Law.

Mr. Saunders is "mentally ill" as defined by CPL 330.20 and section 1.03 of New York State Mental Hygeine Law. He suffers from mental disorders: My diagnoses are 1) Psychotic Disorder NOS (the differential diagnosis being Bipolar Disorder, Schizoaffective Disorder, Schizophreniform Disorder, Schizophrenia, Brief Psychotic Disorder); 2) Schizotypal Personality Disorder and; 3) Cannabis Abuse. These mental disorders currently require care and treatment as an inpatient because he has only recently resolved the last psychotic episode, is now beginning to appreciate more fully the nature of the disorder, but still has some denial and ambivalence which could affect compliance, and has only recently agreed to embark on a preventative medication strategy that needs to be assessed for tolerance. He also needs to build confidence that he will adhere to the strategy and have a comprehensive discharge plan designed and prepared to maximize the post-discharge outcome. He convinced me that he does understand that he has a mental disorder, that it has become autonomous and that he and the community are best served by his acceptance and adherence to a preventative medication strategy. As all who have worked with him have discovered, he is careful and cautious consumer of information,

demands that a high level of certainty be achieved about diagnosis and insists on evidence-based treatments. Arguments could be made that his judgment is not "so impaired" that he "is unable to understand the need for such care and treatment..." which would argue for release from inpatient care, but I am not advocating that course.

Mr. Saunders is not "dangerously mentally ill" as defined by CPL 330.20 because he does not "currently constitute a physical danger to himself or others." In fact, he has not demonstrated symptoms or signs of psychosis for nearly four months despite being under ample scrutiny to discover them. His behavioral control has been impeccable for this same period of time. He has been participating in his treatment (albeit nominally and with skepticism in some examples) and has achieved the highest level of privileges that can be attained on the unit because of his excellent behavioral control and his compliance with the psychosocial elements of his treatment plan.

You also asked me to opine about whether or not Mr. Saunder's is a candidate for treatment over objection with psychotropic medications. My answer is no. He has sufficient understanding and insight to recognize that he has a mental disorder and agrees with the general nature of its classification as a recurrent psychotic disorder of unclear etiology. He acknowledges that is has become autonomous. He understands that the uncertainty about diagnosis makes definitive statements about expected course, prognosis and treatment selection impossible. However, he does acknowledge the condition has become recurrent and autonomous. He accepts that the differential diagnosis that I offered and understands that each of these conditions, when recurrent require preventative medication treatment, especially when one has had severe episodes that have so disrupted one's life course and have become dangerous. and that Among the challenges in accurately diagnosing and optimally treating Mr. Saunders are his personality disorder and other personal characteristics, such as his intelligence and demanding "consumer' mentality that do not fit neatly into the template of the typical patient on CPL status. He is difficult and frustrating to work with because he challenges most assertions of professionals and takes almost nothing at face value. He is inquiring and demands a high level of certainty about diagnosis and the rationale, risks and benefits for evidence-based treatments before he will accept recommendations, and is intimately involved in exploring diagnosis and treatment options. He probably embarrasses clinicians at times when he may know more from his research about a particular issue than they do. These interpersonal issues likely color clinicians' perceptions of him and his perceptions of them, and may interfere with therapeutic engagement both on his part and on the part of clinicians. He demands more time and intellectual effort than most patients. It is important that these characteristics be acknowledged and incorporated into a treatment planning because I predict the quality and durability of his alliance and adherence to treatment will be partially determined by the management of these factors.