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January 31st, 2018

Vicky L. Valvo, Esq.
NYS Mental Hygiene Legal Service
438 Main Street, Suite 400
Buffalo, NY 14202

Re: William Sutherland
DOB: 10/30/65

Dear Ms. Valvo,

The following is the report of my forensic psychiatric evaluation of Mr. Sutherland regarding his objection to the Retention application of Buffalo Psychiatric Center. This is a CPL §330.20 application which is supported by a report and opinion of Kristin Ahrens, M.D., dated October 2nd, 2017. I note that the record contains an almost identical report by the same psychiatrist with an Unescorted On- Grounds application which was completed in January 4th of this year. Unescorted privileges was recommended because Bill "has not acted aggressively in a long time." Bill has been a patient continuously since 3/27/2000. It is important to note that the only aggressive behaviors that he has exhibited in his eighteen years of confinement has been verbal.

Bill Sutherland is well known to me as I have completed previous forensic psychiatric assessments addressing CPL §330.20 status. I provided a report dated November 8th, 2012 regarding the issue of dangerousness and I provided an assessment that he is not "mentally ill" as defined in CPL §330.20 in January, 2016.

Bill Sutherland is a highly intelligent and insightful man. He has a Narcissistic Personality Disorder with secondary Antisocial Traits as well as a history of Alcohol Use Disorder. These brought him into repeated conflicts with people, especially those with power and authority, leading up to the incident in which he was charged with Arson. He had left insulting and inflammatory phone messages for a person of substantial public profile, wealth, and power in Buffalo. He has filed numerous complaints for the treatment he and fellow patients received. These have utilized appropriate channels of hospitals and state systems responsible for his retention and treatment.

Historically he was known to tout the possibility of being the son of deceased mobster John Gotti. This has been seen as a delusion rather than an attempt to bolster to his own sense of importance and power. He has steadfastly presented this as something that was suggested to him by people with underworld connections and he considered it a

possibility as he was adopted and knew nothing of his birth parents. When he was arrested on the incident charges he was reported to have claimed this parentage to the arresting officers. Taken as a delusion, it is largely the basis of his receiving diagnoses of psychotic disorders of various types over the years. Careful review of the records and multiple inquiries made directly of Bill found that he never firmly held to this as a belief, he simply repeated what others had told him and that he had considered that possibility. Through his own efforts he has been able to trace his parentage with DNA confirmation and he believes the results which indicate that John Gotti was not his father. His birth father has been identified and he learned that he has a sister through his father. He made contact with her and now has an ongoing relationship. He reports continuing his effort to identify his birth mother as his sister has a different mother.

The other support offered for Bill having a psychotic disorder has been statements made by a former girlfriend. At the time of his arrest in 2000 she reported he had for years been seeing and hearing things, paranoid that people were trying to kill him, having conversations with the Devil, and believed people could channel his thoughts through other people in an effort to communicate with John Gotti, the deceased mob boss. As noted in Dr. Ahrens's reports, Bill has consistently indicated these are false reports and that he never had such beliefs and fears. It is of note that in his eighteen years of scrutiny by numerous psychiatrists and based on the reports of psychiatric staff, there has not been any indication of such delusional ideas since he has entered the forensic hospital system. Dr. Ahrens acknowledges the lack of clarity about any psychotic disorder and indeed reports, "He does not clearly meet criteria for one particular disorder of psychosis." Despite this she still lists as "the working diagnoses include delusional disorder and bipolar disorder, NOS." While acknowledging that he does not believe he is a son of John Gotti now that his biologic father has been identified, "He does, however, continue to substantiate his belief that he 'was' the son of John Gotti with numerous ideas of reference dating back to his teenage years." "He has shown no significant improvements over the past seventeen years of institutionalization with these symptoms."

This is a contradiction to Bill reporting that he has never firmly believed he was the son of the mobster, rather he repeated the ideas that were fed to him by others that he considered it a possibility. Once information to the contrary was definitively obtained, he dropped the idea completely and accepts his parentage and biologic sister. By definition, a delusion is a firmly held belief that is not abandoned when contradictory information is provided. Yet this legacy continues to be perpetuated in the record and acted upon as indication of serious mental illness and reason for continuing involuntary hospitalization. This is still held to be a problem because Dr. Ahrens notes, "Historically, Mr. Sutherland committed a serious felony arson while under the influence of both delusions and alcohol that he continues to accept no responsibility for." It seems that unless he accepts the portrayal of him as having a psychotic disorder and that he acted under the influence of such a mental disease, that he can never be considered healthy enough to return to normal life. His acceptance of his DNA proven family has occurred when not taking antipsychotic medication.

Bill does have attitudes and behaviors that augment his being perceived as dangerous. He has raised his voice on occasion, used explicatives when frustrated or angry, and has written numerous letters of complaint regarding conditions and treatment on behalf of

himself and his fellow patients. Review of the records and of the descriptions by Bill of these incidents where he lost his temper and raised his voice, does not really support the idea that this is a prelude to any dangerous behaviors or that it would precipitate dangerous interactions if he were in the community. They are taken within the framework and context of the legacy carried through in the records. Such otherwise common expressions of frustration and anger seen in the general population, are cast as indicative of mental illness because the diagnosis of a psychotic disorder has been perpetuated. Bill's narcissistic personality and secondary antisocial features, when combined with his high intelligence and acute perceptiveness, is experienced as uncooperative and threatening. He will use official channels to press his point when he feels a rule is entirely bureaucratic and not therapeutic in its aim or result. This contributes to his profile as a threat. He is also experienced as uncooperative. Taken together, these frame the portrait of otherwise common expressions of frustration or anger, such as his caustic comments when he had to end and exercise workout early.

Compared to my previous exams of Mr. Sutherland there has been a transition in using his intelligence and insight therapeutically. In the past he used these assets primarily to shine a light on others. He has focused on limitations or inconsistencies of some of his caretakers or he has used these insights for power within the patient community. The transition evident now is that he is shining this light on his own thoughts and actions. This is an important change that has allowed progress toward better interpersonal relationships such that he is now being considered for unescorted on-grounds privileges. He attributes his progress to psychotherapy with his psychologist, Amy Taublieb. He is coming to understand the wisdom of being diplomatic rather than offensive with those upon whom his emancipation from the hospital depends.

I contacted Amy Taublieb by phone to confirm the nature of their relationship being therapeutic and moving forward with progress. I was informed by Ms. Taublieb that she is prohibited from talking to me. This would be a useful source of information from someone with substantial weekly contact. When asked about his therapy with Dr. Ahrens, he characterized those contacts to be of short duration most often while she was in the public area of the staff desk, at approximately one month intervals. He could not recall having private sessions in recent months that would allow for a comprehensive mental status examination. If this is accurate, the mental status exam provided in the retention application would be largely derivative of reports provided by others, a conglomerate from historical information, with limited direct examination of Mr. Sutherland. For example, under item 7, page 16, he is described as exhibiting "hypergraphia" which could be a symptom of a mania (Bipolar disorder). If manic, the writing would be profuse, disorganized, over productive and unfocused. Of the letters I have read that he had composed, these were quite succinct and focused. The report continues that he has "over inclusive and circumstantial thoughts and generally elevated energy levels." Again these are symptoms that often go with manic features of bipolar disorder or schizoaffective disorder. When I sit and examine Bill, he can be quite energetic and go into great detail but this is always in response to my question, relevant to the issue, and he is easily refocused back to the original question if he has not come back to it on his own at that point. He is quick thinking and can talk fast. These traits have been present throughout his lifetime and are not manifestations of being manic, yet the listing of these traits implies such an illness is active. The report goes on to say "He

has shown no significant improvement over the past seventeen years of institutionalization with these symptoms." Personality and character traits are, by definition, persistent. This assessment he has not improved includes holding that he at some point believed he was the son of John Gotti, which is not an accurate portrayal of his thinking on the subject.

Regarding the Alcohol Use Disorder, this is a potential area of vulnerability as the combination of his personality traits with alcohol is prone to interpersonal conflicts. He has an incomplete appreciation of his vulnerability to alcohol causing problems in his life. As such I had to remind him that he had three DWI's prior to his arrest on the incident event at which point he described his regular attendance at AA and pointed out his relapse prevention plan. He can elaborate the recommended dos and don'ts for people with substance use disorders. Based upon my decades of work with this population and as medical director of a licensed outpatient substance abuse program, I see some risk for alcohol relapse based upon his incomplete acceptance that he cannot drink at all. As discussed in my report two years ago, this can be addressed by requiring urine samples periodically to include ethyl glucuronide testing. This detects alcohol use for up to eighty hours after ingestion. I would emphasize here that the incident event leading to his long confinement did involve alcohol use and it is conceivable that something was added to one of his drinks as he has always contended. Whether he was drugged or not, he experienced a blackout (absence of memory for the events) likely from drinking too much too fast that night. It is also important for Bill to continue psychotherapy to further gain competence in his interpersonal effectiveness. This can be accomplished in a community setting.

We did discuss the hospital's community residence as part of a step down program from his long inpatient stay. He notes that these "residences" are simply other floors in the same building in which he now resides so is not a true transition into the community. He notes that the availability of drugs and alcohol in that setting is counter to his relapse prevention strategies and that being in that location would be a logistical problem for the employment that he would like to resume.

Opinion

With a reasonable degree of medical certainty, William Sutherland at this time does not require continued confinement in an inpatient psychiatric hospital. In that sense, he is not mentally ill as defined in CPL§330.20. Were he to be examined by a psychiatrist for his need to be hospitalized, based on his presentation at this time, there would be no legitimate reason for him to be involuntarily hospitalized. I do not agree that he can be characterized, as in the last paragraph of Dr. Ahrens's report, of demonstrating "clinical instability". His refusal of medication is rational considering he does not have active psychotic symptoms nor any features of mania nor a clear diagnosis of Bipolar Disorder. I also disagree that he lacks insight as he is able spontaneously to talk about how he deals with situations and people that have been problematic and his need to further address his personality disorder. His "history of significant retaliation against others" must be seen within the context of filing complaints using appropriate channels. He has never attacked any staff or any other patients physically and his verbal expressions of frustration and anger are within the range of what is commonly seen in the community. He is working through the CPL privileging system at this time. He has cogent reasons to reject the

hospital based "community residences"; this should not be a requirement. He is not a persistently seriously mentally ill person with the cognitive impairments, chronic psychotic features, and lack of initiative that is characteristic of the population for which that residence was designed.

This completes the report of my assessment regarding Mr. Sutherland's current CPL §330.20 status. Please contact me for further discussion or elaboration on any points that need clarification or elaboration.

Sincerely,

Gary J. Horwitz, M.D.
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