Stuart Grassian, M.D.
401 Beacon Street
Chestnut Hill, MA 02467
(617) 244-3315; fax (617) 244-2792
stgrassian@gmail.com

Declaration: Psychiatric Report in S.H. v. Reed

I, Stuart Grassian, M.D., pursuant to 28 U.S.C. § 1746, declare under penalty of perjury that the following is true and correct:

1. Background, General Observations.

My name is Stuart Grassian, M.D. I am a Board-certified psychiatrist, licensed to practice medicine in the Commonwealth of Massachusetts. My C.V. is attached hereto. I have extensive experience in evaluating the mental health care afforded to adults and adolescents in confinement, whether in adult prisons or juvenile detention facilities, or in locked psychiatric units. I also have substantial experience in evaluating and treating institutionalized adolescents with major behavioral problems in locked psychiatric wards, some of whom had previously been in correctional facilities. In addition, I have a particular expertise in evaluating the psychiatric effects of isolated confinement.

In the present litigation, I was retained by Attorney Al Gerhardstein, Gerhardstein and Branch, Cincinnati, Ohio and Kim Tandy of the Children's Law Center of Covington Kentucky and asked to review documents related to the confinement of juveniles in Ohio's DYS facilities, with especial focus on the use and effects of isolated housing and the mental health care provided the youths therein detained. A list of the documents I have reviewed to date is separately attached. These documents include policies and procedures, proposed changes and results of changes in the operation of the Scioto JCF (SJCF) PROGRESS units, and medical and mental health files of six youths who have been housed in those units in 2012.

Attachment C

1.1 Segregated confinement of inmates

My observations and conclusions generally regarding the psychiatric effects of solitary confinement, and the adequacy of mental health care to inmates who are, or become mentally ill, have been cited in a number of federal court decisions, for example: *Davenport v. DeRobertis*, 844 F.2d 1310 (7th Cir. 1988), and *Madrid v. Gomez*, 889 F. Supp. 1146 (N.D. Cal. 1995).

I prepared a written declaration for *Madrid* describing the medical literature and historical experience concerning the psychiatric effects of restricted and isolated conditions of confinement as well as of other conditions of restricted environmental and social stimulation, and subsequently prepared the general (non-institution specific) and non-redacted (non-inmate specific) portions of that declaration into a general statement, which I have entitled *Psychiatric Effects of Solitary Confinement*, 22 Wash. U. Journal of Law & Policy (2006). This paper is attached hereto and incorporated herein. It describes the extensive body of literature, including clinical and experimental literature, regarding the effects of decreased environmental and social stimulation, and more specifically, observations concerning the effects of segregated confinement on prisoners.

I have given lectures and seminars regarding these issues. Although I do not have a complete list of those lectures and seminars, they include, but are not limited to, lectures at Harvard Medical School-Beth Israel Hospital, Boston, at meetings of the Nova Scotia, Virginia and New York State Bar Associations, The Office of Military Commissions of the U.S. Department of Defense, The Federal Capital Defenders Habeas Unit and The Correctional Association of New York, as well as, invited testimony before state legislative hearings in New York, Massachusetts and Maine. I have been retained as an expert in class-action lawsuits regarding these issues in Massachusetts (2), New York (3), California (2), Kentucky, Michigan, Ohio, New Jersey (Juvenile Detention), Texas (Juvenile Detention) and Florida, as well as individual cases in other states, including California, Connecticut, Florida, Georgia, Maine, Massachusetts, New Mexico, New

York, Pennsylvania, Texas, Virginia and the State of Washington. I have been retained and consulted by a variety of public advocacy groups, including The Legal Aid Society of New York, Prisoner's Legal Services of New York, the Center for Constitutional Rights, The Massachusetts Correctional Legal Services, The Massachusetts Civil Liberties Union, the National Prison Project of the American Civil Liberties Union, and the Department of Corrections of the State of Florida. I have also been appointed to the Advisory Committee of the New York State Commission on Quality of Care & Advocacy for Persons with Disabilities.

Since the tragic events of September 11, 2001, I have also been consulted regarding the confinement of a number of individuals who were deemed to be "enemy combatants" and/or were either charged with or convicted of conspiring against the United States. These include individuals who were confined in Guantánamo, in the Navy Brig in Charleston, S.C., in the Federal ADX prison in Florence, Colorado and in the SeaTac facility in Seattle, Washington, as well as in federal detention centers in New York City and Miami, Florida.

1.2 Institutionalized Adolescents with Behavior Problems.

In addition to my involvement in class-action lawsuits regarding Juvenile Detention Facilities, I also have extensive clinical experience in evaluating and treating adolescents with behavioral problems associated with delinquency, substance abuse, psychiatric illness (especially, Attention Deficit Hyperactivity Disorder and Bipolar Mood Disorder). My clinical involvement with these youngsters has generally been in psychiatric inpatient settings, inpatient and outpatient addictions treatment programs, and in individual or family outpatient treatment. I have served as Director or Clinical Director on two Inpatient Units serving adolescents and adults as well as at an Addictions Day Treatment Program, have been an Attending Psychiatrist at an inpatient Addictions Unit, as well as a Supervising Psychiatrist for an Addictions Outpatient Clinic. In 1994, I was granted subspecialty certification in Addictions Psychiatry by the American Board of Psychiatry.

It might be thought that this patient population is very different from the population experienced in a Juvenile Correctional Facility. That, however, is quite often not the case. In my professional experience, spanning almost thirty years, I have come to recognize that it is often just a matter of luck as to whether a behaviorally disruptive or delinquent adolescent ends up going through the correctional system, or whether he is deemed more appropriate for a psychiatric hospital. Indeed, I have treated quite a number of youngsters who at some points were hospitalized, and at others were incarcerated in a Juvenile Correctional Facility. They sometimes bounced back and forth, and when hospitalization was deemed more appropriate, they once again became my patient.

Indeed, I recall one youngster in particular who had been hospitalized under my care (I was the head of the locked adult and adolescent unit there), assaulted a nurse and was jailed, I was brought by the prosecution to testify at a hearing about his mental state and about what had happened on my unit. The result of the hearing was that he was deemed to be more appropriate for a psychiatric unit, and the Court ordered that he be returned back to my care, back to a hospital setting without chains, handcuffs, shackles, spit masks, or the capacity to keep a person in isolated confinement. He did fine.

I would like to explain how this could be. All of these adolescents had some combination of severe problems with impulse control - impulsivity, emotional volatility, explosive anger, and for many or most – addictive behavior and/or bipolar mood disorder. Many seemed to be dedicated to fight against any assertion of authority, and many had committed acts of violence.

Obviously, the population that I have treated clinically is not identical to the population of a Juvenile Correctional Facility, but there is a spectrum of presentations in each of these, and there is a great deal of overlap. Indeed, one of the most striking experiences I have had when retained in litigation regarding Correctional and Detention Facilities is having individuals pointed out to me who were deemed to be so rageful and violent that they could never be released from segregated confinement. Eventually, some of these

suits were concluded, with the Facility accepting its need to recognize the psychiatric underpinnings of their dangerous behavior, and hence to reframe its approach to them.

In one particular case, the results were so dramatic – the incidence of violence, screaming, fecal smearing, and so forth – declined to almost zero, that not only was this a blessing to the inmates, it was also a blessing to the correctional staff, whose jobs were no longer filled everyday with screaming, horribly noxious odors, and the constant apprehension of violence. The segregated unit had become generally quiet, clean, no longer an ordeal for all who had to participate in it.

Any system of care and treatment must monitor itself, to assess in some fashion if it is working, and certainly to ensure that it is not making things worse. Many individuals within the correctional system have acknowledged that while their stringent responses to disruptive behavior create some safety in the short run, they often do make things worse in the long run. Elaine Lord was warden at the Bedford Hills Correctional Facility in New York State during a class-action suit challenging its use of solitary confinement. In a lecture, she lamented that once inmates committed infractions resulting in a stay in solitary confinement, they seemed to spiral downhill – becoming more and more out of control, thus incurring more and more time in solitary, all in an unending cycle. She coined this problem "maxing out" – once inmates got into that vicious cycle, they got worse and never got out.

It is not an uncommon problem. I recall evaluating one young man in a maximum security institution. He had spent almost all of his incarceration in solitary confinement, and while in solitary had become increasingly out of control, leading to acts of aggression, and further criminal prosecutions causing his confinement to be prolonged far longer than his initial sentence. He clearly had psychiatric problems involving impulsivity, emotional volatility and poor judgment; if I recall, he was diagnosed with some form of bipolar mood disorder as well as a substance abuse disorder. The tragic thing about it was that although his preincarceration history was rocky, it was not

particularly awful. And his committing offense – at the age of eighteen – was just stealing a bicycle. It was his first encounter with the criminal justice system.

Among the records I reviewed in the present litigation, there were a number of records demonstrating this "maxing out" – youngsters who were fairly cooperative with staff at intake, eventually committed some infraction causing them to be placed in isolation, and then the isolation going on and on and at some point the youngster's behavior worsening to the point that he and the staff were stuck in a intensifying cycle of rage on the one side and harsh control and deprivation on the other. I would like to address why I believe this happens in correctional settings, and what advantages seem to flow when the behavior is viewed within a psychiatric framework.

1.3 The Correctional and the Psychiatric Paradigms

As I understand it, the Correctional paradigm centers about themes of control, discipline, and security. Intrinsic to it is the central concern that the subjects are willful, manipulative – waiting to see a weakness – and intentionally violent. Security has to come first; nothing good – including any kind of treatment - can happen if we lose our vigilance, and if that means segregated confinement, then so be it – whatever the cost. Discipline must be strict and punishment for deviation must be inevitable, and harsh enough to teach the subject a lesson. These subjects are willful; they will manipulate and control if given a chance to do so. They have to be taught that we, not they, are in control, that we, not they, will assert our will. We cannot let there be any laxity in our control; one small gap will simply encourage others, and potentially lead to an escalating, out of control and increasingly dangerous situation.

This paradigm is not unique to corrections. There are some addictions treatment programs that seem to adhere to it – almost a need to first break the patient down so that he can then, later, be reformed into a healthier person. As described later in this statement, I believe that, while well-intentioned, when such a paradigm is employed as treatment, rather than just warehousing, it is almost doomed to fail. And when that

paradigm is justified purely for the safety of those inside a correctional institution, it fails to recognize that while it creates immediate safety, in the long run it just breeds more violence and thus becomes a vicious cycle of brutal control and brutal, chaotic aggression.

The psychiatric paradigm is more multidimensional, more flexible. While limits have to be set on disruptive or dangerous behavior, they are not really the focus – the comfortable default position. There is a recognition that for behavior to improve over time, there must be a respectful engagement, an alliance, formed with the individual. He will not change in any positive manner if he perceives staff as punitive, cruel, unjust, demeaning. There is also a willingness to see behavior as not just "willful", but instead to look deeper in order to understand what the individual experiences, what goes on in his head. For example, in this case, at least one youth was extremely frightened of how out of control were his violent impulses; they had become entirely obsessive, intrusive, unwelcome. He pleaded with his clinician to not let staff take him out of his cell because he was frightened he would kill someone.

2. The Psychiatric Effects of Isolation and Segregated Confinement.

2.1 Generally.

It has long been known that severe restriction of environmental and social stimulation has a profoundly deleterious effect on mental functioning; this issue has, for example, been a major concern for many groups of patients including, for example, patients in intensive care units, spinal patients immobilized by the need for prolonged traction, and patients with impairment of their sensory apparatus (such as eye-patched or hearing impaired patients). This issue has also been a very significant concern in military situations and in exploration - polar and submarine expeditions, and in preparations for space travel.

In regard to segregated confinement, the United States was actually the world leader in introducing prolonged incarceration - and solitary confinement - as a means of dealing with criminal behavior; the "penitentiary system" began in the United States in the early

19th century, a product of a spirit of great social optimism over the possibility of rehabilitation of individuals with socially deviant behavior. This system, originally embodied as the "Philadelphia System," involved almost an exclusive reliance upon segregated confinement as a means of incarceration, and also became the predominant mode of incarceration - both for post conviction and also for pretrial detainees - in the several European prison systems emulating the American model at the time.

The results were catastrophic. The incidence of mental disturbances among prisoners so detained, and the severity of such disturbances, was so great that the system fell into disfavor and was ultimately abandoned. During this process, a major body of clinical literature developed which documented the psychiatric disturbances created by such stringent conditions of confinement. The paradigmatic disturbance was an agitated confusional state which, in more severe cases, had the characteristics of a florid delirium, characterized by severe confusional, paranoid, and hallucinatory features, and also by intense agitation and random, impulsive violence – whether directed at others or self-directed.

The psychiatric harm caused by solitary confinement became exceedingly apparent. Indeed, by 1890, in In re Medley, the United States Supreme Court explicitly recognized the massive psychiatric harm caused by solitary confinement: "This matter of solitary confinement is not ... a mere unimportant regulation as to the safe-keeping of the prisoner .... [E]xperience [with the penitentiary system of solitary confinement] demonstrated that there were serious objections to it. A considerable number of the prisoners fell, after even a short confinement, into a semi-fatuous condition, from which it was next to impossible to arouse them, and others became violently insane; others still, committed suicide; while those who stood the ordeal better were not generally reformed, and in most cases did not recover sufficient mental activity to be of any subsequent service to the community."

The consequences of the Supreme Court's holding were quite dramatic for Mr. Medley. Mr. Medley had been convicted of having murdered his wife. Under the statute in force at the time of the murder, he would have been executed by hanging after about one

additional month of incarceration in the county jail. But in the interim between the crime and his trial, the Colorado legislature had passed a new statute that called for the convicted murderer to be, instead, incarcerated in solitary confinement in the new Colorado State Penitentiary during the month or so prior to being hung.

Mr. Medley's attorneys argued that punishment under this new law was so substantially more burdensome than punishment under the old law, as to render its application to him *ex post facto*. The Supreme Court agreed with him, even though it simultaneously recognized that if Mr. Medley was not sentenced under the new law, he could not be sentenced at all, since the old law was rescinded when the new law was passed. Despite this, the Court held that *added to a sentence of death on the gallows, this additional punishment of one month of solitary confinement was simply too egregious to ignore*; the Court declared Mr. Medley a free man, and ordered his release from prison.

It sometimes seems like we have come a long way downhill from there.

Dramatic concerns about the profound psychiatric effects of such conditions of isolated confinement have continued into the twentieth century, both in the medical literature, and in the news. The alarm raised about the "brainwashing" of political prisoners of the Soviet Union, Communist China, and especially of American prisoners of war during the Korean War, gave rise to a major body of medical and scientific literature concerning the effects of sensory deprivation and social isolation, including a substantial body of experimental research.

It is troubling that this history is somehow overlooked by those who freely employ segregated confinement today. This history and literature, as well as my own experience and observations, has demonstrated conclusively that, deprived of a sufficient level of environmental and social stimulation, individuals will soon become incapable of maintaining an adequate state of alertness and attention to the environment. Indeed, even a few days of solitary confinement will predictably shift the electroencephalogram (EEG) pattern towards an abnormal pattern characteristic of stupor and delirium.

This fact is, indeed, not surprising. Most individuals have at one time or another experienced, at least briefly, the effects of intense monotony and inadequate environmental stimulation. After even a relatively brief period of time in such a situation, an individual is likely to descend into a mental torpor - a "fog" - in which alertness, attention and concentration all become impaired. In such a state, after a time, the individual becomes increasingly incapable of processing external stimuli, and often becomes "hyper-responsive" to such stimulation; for example, a sudden noise or the flashing of a light jars the individual from his stupor, and becomes intensely unpleasant. Over time, the very absence of stimulation causes whatever stimulation is available to become noxious and irritating.

An adequate state of responsiveness to the environment requires both the ability to achieve and maintain an attentional set - to focus attention - and the ability to shift attention. The impairment of alertness and concentration in solitary confinement leads to two related abnormalities:

a. First, the inability to focus, to achieve and maintain attention, is experienced as a kind of dissociative stupor - a mental "fog" in which the individual cannot focus attention, cannot, for example, grasp or recall when he attempts to read or to think.

b. Second, the inability to shift attention results in a kind of "tunnel vision" in which the individual's attention becomes stuck - almost always on something intensely unpleasant - and in which he cannot stop thinking about that matter; instead, he becomes obsessively fixated upon it. These obsessional preoccupations are especially troubling. Individuals in isolated confinement easily become preoccupied with some thought, some perceived slight or irritation, some sound or smell coming from a neighboring cell. This preoccupation grows to the point that it becomes maddening. In my first published article on this subject[1], I described the struggle to control increasingly obsessional violent

[1] Grassian, S. : *Psychopathological Effects of Solitary Confinement.* American Journal of Psychiatry, 140:11, 1983.

thoughts of revenge: "I try to sleep 16 hours a day, block out my thoughts – muscles tense – think of torturing and killing the guards … I can't stop it. Bothers me. I have to keep in control. This makes me think I am losing my mind. Lay in bed too much – scare yourself with thought in bed. I get panicky – thoughts come back. – picture throwing a guard in lime – eats way at his skin, his flesh – torture him. Try to block it out, but I can't."

2.2 Individual Differences in Response.

There are substantial differences in the severity of the effects of such confinement. Isolated confinement challenges the individual's capacity to maintain alertness and attentional set, as well as his capacity to control his emotional reactions and impulses. Thus, it is not surprising that neuropsychiatric conditions strongly associated with such difficulties render the individual far more susceptible to the toxic effects of isolation.

Among psychiatric diagnoses, Attention Deficit Hyperactivity Disorder (ADHD) and Bipolar Mood Disorder (BMD) are especially marked by such difficulty. And these two diagnoses in fact have much in common; indeed, approximately 95% of individuals with BMD meet criteria for the diagnosis of ADHD (except for age of onset; in ADHD, onset will be in childhood, while BMD more typically has onset in adolescence or later). The particular pathogenicity of BMD in solitary confinement was, for example, reflected in Madrid v. Gomez, the major class-action lawsuit involving the notorious Pelican Bay State Prison in California; in response to the incidence of major psychiatric disturbance among inmates with Bipolar Mood Disorder in the Pelican Bay Special Housing Unit (SHU), the Federal Court's decision caused a diagnosis of Bipolar Mood Disorder to result in a lifetime exclusion from the SHU.

Similarly, individuals with central nervous system dysfunction and cognitive impairment are particular susceptible to the toxic effects of solitary. They are less capable of using their own mental processes – their own thinking – to maintain some degree of stimulation

from inside their own head, and they also have less internal coping tools with which to manage their emotional reactions and impulsivity.

And of course, adolescents – their brain function and emotional control still not fully developed – are especially vulnerable. Adolescence is indeed marked by impulsivity and emotional reactivity. New technologies have allowed us to recognize and observe brain plasticity, that brain function and neural connectedness are still evolving and developing during adolescence, especially so in regard to the functioning of the frontal lobes – that part of the brain most centrally involved in inhibiting emotional reactivity, to mature the capacity to think before acting. Moreover, it has become clear that the reaction to stress, modulated through the brain's hypothalamic-pituitary-axis, is massively affected by stress in youth.

It is very frightening to consider that it is probable that a harsh, punitive approach in juvenile correctional facilities will permanently affect the youth's capacity to modulate affect and to inhibit impulsivity, likely permanently impairing his capacity to manage his life as an adult.

3. Observations Regarding ODYS and the PROGRESS Units.

3.1 Background.

The present litigation grew out of a number of concerns, including the grossly excessive amount of time youths were being housed in conditions of isolated confinement, the lack of adequate programming, the inadequacy of mental health response and involvement, and the lack of training and understanding of mental health issues provided to the juvenile corrections officers. In the settlement of the lawsuit, the defendants agreed to make major changes in each of these areas.

However, recent documents – including mental health monitoring reports, correspondences between plaintiffs and defendants in the case, and so forth – have

acknowledged that these changes have not been implemented to an adequate degree. Youths on the PROGRESS units are in general still being housed for extremely long periods of time in isolated confinement with harsh restrictions on their occupational, social, perceptual, and recreational opportunities – including virtually no outdoor recreation. In this statement, I will take as a starting point what is present today, not what the defendants assert will occur in the future.

3.2 Opinions Regarding the Scioto PROGRESS Units, Generally.

3.2.1 A Punitive, Correctional Bias.

While the term "Juvenile Corrections Officer" has been replaced by the term "Youth Specialist", it appears that these staff members are not deeply educated about the mental health issues of the youths they serve. This is a very serious problem. In maximum security settings, and even in psychiatric hospitals, behavior can be unpredictable and potentially dangerous. When staff lack the ability to understand the individuals they serve, to conceptualize such behavior and its meaning, they have no alternative but to live in a world of constant tension. And almost invariably, that tension – that waiting around for something bad to happen - leads to anger and contempt towards the individuals causing them that constant state of fear and tension. Almost inevitably, the staff are pulled towards wanting to control the situation, to show their scorn, to make something happen.

As I described above, in solitary confinement, irritations and frustrations can become an increasing focus, leading to unmanageable rage. In virtually all of the charts that I reviewed, the issue of respect is a central one.

A.B., seen as one of the most dangerous youths on the Cedar Unit, described this very poignantly. He spoke several times of how he felt the custodial staff were "setting him up". On March 24, 2012, a clinician, Pamela Thiese, Psy.D., spoke with him through his cuff port. He commented that he imagined she could not believe how disruptive and aggressive he had been recently. She acknowledged that she found it hard

to believe, given the quality of her interactions with him. He responded: "You respect me, I respect you. You treat me like a dog, I start to act like a dog."

Similarly, during the Spring and early Summer of 2012, several of the youths whose charts I reviewed apparently experienced the custodial staff in the Cedar Unit (then a Phase I unit) as actually being more respectful of them than the staff of the Sycamore Unit (then Phase II). As a result, although they had been promoted to Phase II, they could not stay there. They became defiant, unruly – some even expressed a desire to return to Cedar.

In psychiatric hospitals, there is a strong commitment to involving custodial staff in learning about mental illness and abnormal behavior. There are case conferences – usually about an hour or more in length - in which a patient's history and current presentation is reviewed, then he is interviewed by a clinician, and then there is a joint effort at understanding what has been happening and how to make it better. These conferences help to more deeply understand the individual being discussed, but they serve a more fundamental purpose, almost like a ritual that allows the whole staff, clinical and custodial, to become a team that worries about and thinks about how to help the patients they serve. It gives dignity to the work, a shared sense of responsibility to make things better. And in my experience, when that work is not done, psychiatric hospitals can descend into the same controlling, punitive, scornful position that is all too common in correctional facilities.

Similarly, whether in a psychiatric hospital or a juvenile detention facility, there must be very frequent opportunities for something good to happen on the unit, for the staff to feel a sense of pride, that they are accomplishing something. When, as in the PROGRESS units, virtually all that they see and invoke is punishment and deprivation, very little happens that is positive. The universe becomes one of pervasive control, anger, and defiance. In such a context, it is very difficult for custodial staff to not start treating their wards "like a dog".

There is almost a kind of "newspeak" invoked. The youth on the PROGRESS units are housed in "rooms". But those "rooms" are barren concrete boxes, with solid steel doors and a cuff port, no different from the solitary confinement cells in adult prisons. All of the six youths whose charts I reviewed in this matter have been housed in Phase I in the Cedar Unit for extended periods of time. They are not let out of their cells except maybe for a narrow range of activities, groups, or classes, but mostly it is irrelevant – it seems that there are hardly ever enough staff present to allow youths out of their cells. So in the end, they spend day after day, month after month, virtually continuously in what amounts to a solitary confinement cell. Indeed, in many ways their conditions are worse than that in solitary confinement in prison; they are not allowed reading material, writing or drawing material,[2] nor close circuit television[3] for educational programming. The stringencies are extravagantly harsh. Youth were even deprived of palatable food – provided instead with cold "bagged meals", until defendants agreed to desist from this practice in response to a demand by plaintiff's counsel.

Yet in the "newspeak" employed, being on Phase I is deemed not to be "seclusion". Instead, it is deemed to be "Programming". So that the huge number of hours of seclusion that have been charted in this case in fact represents only a small fraction of the time that youth spend in harsh conditions of solitary confinement. Whether they call it "seclusion" or "programming", the result is the same. The youth is left day after day, week after week, month after month, in a barren empty cell with almost nothing to occupy his mind or body. The labeling comes to seem almost cynical.

3.2.2 An Unwillingness to Recognize that Such Confinement is Harmful.

[2] I understand that there have been problems with youths using paper to cover the window in their cells. The same problem does occur in adult prisons, but when prisoners are clear about the choice they make, they almost always desist from using their materials in such a fashion. It should be an individualized decision, a matter of discussing, not permanently depriving Phase I youth of these materials.

[3] It might be thought that it would be impossible to have a television monitor placed in such manner that it could not be tampered with or destroyed. The reality is, though, that it has been done even in the very harshest conditions of the federal prison system – the ADX in Florence, Colorado.

One of the most disturbing facts evident in the chart reviews is that this wholesale use of solitary confinement is causing severe, possibly permanent, harm to the youths so confined. In almost all of the cases, upon entry into ODYS, the youth seemed to engage with the evaluator, to be hopeful about getting something positive from his experience. But after months or years of punitive confinement, he hardens; the worst part of himself becomes more and more dominant. For example:

When C.D. arrived at DYS in June 2011, he was immediately placed in seclusion despite the fact that at reception assessment, he was described as "polite and cooperative". "He put effort into the interview. … Since at Scioto he has abided by the rules and displayed a positive attitude. He tends to display a positive attitude with his peers/staff." Psychologist Irv Jones did a "reception risk assessment". C.D. spoke about wanting to finish high school; he described himself as respectful, someone who got along well with others. Dr. Jones seems to have concurred with C.D.'s confusion about being placed in seclusion: "Youth has no idea why is on status from the Detention Center. He is calm as evidenced by his presentation and answers to the Risk Assessment Interview. He is no danger to himself or others."

Inevitably, as he remained in seclusion for months, his initial positive adjustment did not last. Punitive responses to even minor behavioral infractions resulted in more and more segregation. In mid-October 2012 he still was in isolation, in Phase I in the Cedar Unit.

3.3 Inadequacies of Mental Health Evaluation and Treatment.

A prefatory note: Although I find that there is clear evidence of cynicism and deliberate indifference in the mental health responses at Scioto, I do not mean to condemn each and every clinician as callous and uncaring. There are a number of psychotherapy notes reflecting concern and care, and the OT notes are especially so.

3.3.1 Grossly Inadequate Charting.

It might seem odd that I begin this discussion by focusing on charting, but in this case, the gross neglect of appropriate charting reveals a pervasive pattern of inadequacy: Consider what would happen if there were no charting at all. The history and observations recorded in prior encounters would be lost. Each observation would become an entity onto itself, *sui generis.* Diagnoses would change randomly. Improvements and regressions of psychiatric status and behavior could never be tracked; one would never be able to begin analyzing what factors are at play (e.g. changes in medication, peer influences, staff disrespect, family involvement or the lack thereof, or – of course, prolonged confinement in solitary).

Mental health treatment in prisons is often grossly inadequate, and notes do have the appearance of being *sui generis,* without any reference to what has been learned and observed in the past. Yet even then, there is at least the possibility of reviewing the record, for record-keeping is organized. The charts I reviewed are not. When I first requested mental health records to review, I was provided with a set of records that were virtually devoid of any deep content, any notes describing clinical contacts, therapy notes - any detailed description of what the youth said, did - how he interacted with a clinician. What was included gave no feel for what was really going on inside the youth's head. I insisted that there must be more, and asked Attorney Tandy to make further inquiry. Eventually I did receive what appears to be the complete file. Along with the "official" psychology file there is another section. The defendants inserted a note introducing the section, almost attempting to make an excuse for them: "NOTE This section contains SW entries that do not traditionally reside in Psychology Case File. They may duplicate notes entered by the Psychology Clinician. The "SW" database notes have been added at the Monitor's Request."

Apparently, "SW" stands for social work. However, there is far more than social work notes in this section. Indeed, the SW file is far bigger than the entire rest of the chart (roughly 2-3 times as large). The SW file contains detailed psychotherapy notes, detailed

descriptions by the Occupational Therapist, a number of Psychiatrist notes, etc. Almost all that is rich, that gives clues as to what is going on inside the youth's mind, is contained in a section that is not included in the official chart. I inquired of Dr. Weisman, the mental health monitor in the case, whether she had seen this SW section when she reviewed charts at Scioto. She stated that she was not even aware it existed.

And it seems almost certain that the clinical staff never look at what is contained in the SW file. There is no organization at all in that section; it is almost pure chaos, pages placed in it willy-nilly, with no plan, neither tabs separating different kinds of notes nor a chronological organization to the material. Indeed, in one chart, there were several pages of notes of a <u>different</u> youth. It was obvious and glaring as soon as one turned to those pages. Obviously, if staff had actually read that section, they would have immediately realized these pages did not belong in this youth's chart, but rather in that of some other youngster.

One wonders why this section was not revealed but instead kept hidden. Perhaps because they made apparent the chaotic, indifferent nature of the charting. But perhaps for another, more cynical reason, discussed below:

3.3.2 2012 Reorganization of the PROGRESS Unit.

During the early months of 2012, the defendants announced a reorganization of the Scioto PROGRESS Units, ostensibly intended to meet the requirements they had agreed to in the settlement of this case. They claimed that they would transform the Cedar Phase I PROGRESS unit into a short-term (approximately three week) intensive treatment facility. In reading the first chart, one might be very impressed. For example, in A.B's Psychology summary dated 8/1/12:

> When A.B. arrived on the Cedar unit, his psychological expectations had begun to adjust significantly as he perceived the team as supportive of his success and ability to progress thru the program. To set the atmosphere, transferring youth were asked to sign a "Pledge of personal integrity" with new psychology staff, which he did eagerly. The purpose in this pledge was to serve as demarcation "from old-to-new" in his mental outlook and behavioral self-

> expectations. In reviewing his psychosocial history past psychological and treatment information and in interviews with the youth, it appeared that issues of loss, abandonment and lack of self-identity were pervasive in his early and middle childhood and criminal history. His criminogenic needs were identified as: 1) identifying antisocial personality traits; 2) demonstrating pro-criminal attitude; 3) having social supports for crime; 4) marked problems in family relationships; 5) having a history of poor school performance; 5) lack of involvement on *(sic)* pro-social recreational/leisure activities. Thus (A.B.'s) factors for success were envisioned from the perspective of a risk/need model. …
>
> **Overall Progress Comments:**
>
> One of the first interventions employed was a more comprehensive psychiatric evaluation for his diagnostic and psychotropic and medications needs. His true diagnostic picture had been cloudy since arriving at SCJF and his medication effectiveness and compliance were the subject of many clinical discussions. His medications were adjusted and good compliance a regime *(sic)* established by 5/17/12 prior to his return to Sycamore as a Phase II.
>
> Next, the youth was seen daily for door checks by all staff. Of note is the time taken by the Cedar Youth Specialists, culturally relevant providers and competent in understanding his developmental needs as a young man, and able to apply discipline in a manner consistent with policy. Verbal skills were always are *(sic)* part of processing with youth when he becomes non-compliant with the Cedar unit rules and expectations. As a result his AMS reports and problems with disruptive behaviors dropped markedly. See AMS reports.
>
> These unit changes were followed by a more focused treatment approach of groups and individual contacts focus *(sic)* on his past losses, violence, life on the streets, and trauma. An active participate in Trauma group, (A.B.) disclosed much about his family life and his criminal friends and "life on the edge" activity. … As the therapeutic relationship developed the next area of focus was to help the youth begin to establish a self-identity other than that of a "drug dealer" or other criminal activity. …
>
> Finally, as the Cedar PROGRESS Unit utilizes a focused short term behavioral stabilization and intervention approach, within approximately 21 days the youth's attitude and behavior and stabilized sufficient *(sic)* for him to advance to Phase II.

This sounds good. There are only two problems:

First, it is boilerplate. The same words, with precisely the same grammatical errors, are found in several other charts. It is apparently generated by pressing a couple of buttons, and then adding a small bit of individualized language. (This use of boilerplate is found in other areas of the charting as well – for example, the seclusion observation notes that were used prior to the development around June 2012 of a check-list form.)

Second, it is utterly misleading; the material in the SW section squarely contradicts the rosy picture presented in the boilerplate. Those notes reveal that on April 23, instead of "eagerly signing the Pledge of Integrity", he was actually defiant and angry, refusing to close his cuff port and involved in a confrontation with staff. He was "promoted" to Phase II and transferred to Sycamore sometime in the latter part of May. So he "had gotten in phase" within a few weeks. But had he "earned" it? There was no difference in his defiant anger nor in his behavior, nor in the conditions of his housing, while he was housed in Sycamore. Indeed, he remained in solitary – in seclusion – while housed in Sycamore. In early June, he was transferred back to Cedar, and once again rather quickly "earned" a Phase II transfer to Sycamore. It was just a shell game. There was no change; in the SW section, there is a June 28, 2012 note by Andrea Hafner, MSW: "He is difficult to work with. Moving him to Phase Two may be the team's way of taking a vacation from his problem."

Thus, it is clear that this particular form of boilerplate, and the transfer to Sycamore after "approximately" three weeks, was meant to give the appearance of improved treatment and result, but in fact it was rather a rather cynical writing.

3.3.3 Lack of Integration of History and Observations.

The charts reveal that there were dramatic fluctuations over time in a youth's presentation – at times rageful and out of control, at other times calm, polite, respectful. The gradual deterioration over time in solitary is only part of the picture. There were major fluctuations over time.

As stated above, without a careful review of history and prior observations, it is impossible to understand what that history, or those fluctuations might teach us – what insight they might provide. Without that, there is little that can be tracked other than behavior itself – whether, simplistically, "good" or "bad". The "official" Psychology File describes many moments of attitude and behavior, but almost entirely devoid of analysis. In my review of the charts, I so often wondered how different things could have been if

there had a more thorough, a deeper and more thoughtful attempt at understanding. For example, before his commitment to DYS, E.F. had been diagnosed with ADHD and had been on both Adderall, a stimulant medication, and also Clonidine, a calming medication often used in treating the associated hyperactivity. His adoptive parents informed staff that these medications had been very important; he had been much calmer since he was on them.

This is not an uncommon observation. Stimulants (even cocaine) tend to have a paradoxical effect on individuals with ADHD. Instead of stirring them up, as would be seen with most other individuals, they often become calmer, quieter. Indeed, in evaluating individuals with substance abuse problems, some favor cocaine and stimulants; when asked why they particularly like those drugs, a subgroup will explain that those drugs "mellow me out". Those individuals have ADHD.

The reason for this is fairly straightforward. Individuals without ADHD experience a reasonably normal level of alertness; stimulants speed them up beyond the normal. Conversely, those with ADHD struggle with being not quite alert enough. And like an overly tired child, that impaired alertness does not make them calmer, but more irritable, more reactive, less able to calm themselves. (It is for the same reason that individuals with ADHD have such particular difficulty tolerating the perceptual and occupational deprivation in solitary; lacking a sufficient level of internal stimulation, they need a great deal of external stimulation to keep themselves alert; they are "stimulation seeking".) But when E.F. was initially psychiatrically assessed in DYS, he stated to the psychiatrist that he did not need his stimulant medication. And the psychiatrist simply accepted his claim without further inquiry, discontinuing the medication. The physician apparently never even read or considered his parents' report; there is no mention of it at all, no explanation as to why he would simply accept E.F.'s statement, rather than at least exploring the issue with him, or at least noting the issue in a manner that would keep the issue alive in later evaluations. Instead, the issue died, even while he became increasingly aggressive and out of control while housed in solitary.

In addition, the charts note that many of the youths had prior mental health treatment, whether as outpatients, in some form of residential treatment, or in psychiatric hospital. Those records were apparently never sought. There are no release forms in the chart and no mention of prior mental health treatment records reviewed, or what those records revealed.

3.3.4 Unwillingness to Consider Effects of Conditions of Confinement.

Of the youths whose charts I reviewed, most or all had diagnoses of Borderline Mental Retardation, ADHD, and some form of Bipolar Mood Disorder. In short, from a diagnostic point of view, they were as vulnerable a population as one could imagine. But in reviewing the charts, it is clear that the clinical staff took a strictly "hands off" attitude towards any issue having to do with the conditions of confinement. Youths protested that solitary confinement was "traumatic", but the notes are entirely devoid of any evidence of any consideration of this issue, or any effort to review the literature concerning it. Moreover, these are youths with major impairment in their sense of self-worth, and solitary would them particularly irritable, particularly intolerant of perceived injustice or disrespect. Youths repeatedly spoke of their need to be treated with respect, and that when they were, they were not abusive. There were only some individuals – usually the Corrections Officers (later "Youth Specialists") who enraged them and caused them to explode in violence. This should be critical information for a clinician. But here it is entirely ignored.

Why? Could it be that the clinicians were utterly indifferent and/or grossly incompetent? Perhaps there is another explanation: The power and milieu in prisons and detention facilities too often is that of only one group – the correctional, security staff. Clinical staff who challenge the security staff's perception and approach are at risk of being shunned, their job made much more difficult, even more dangerous. So they ignore what is around them; it is better not to look.

Some of the practices employed in the PROGRESS units seem grotesque. "Groups" were held with the youths confined in their individual cells, shouting out responses to the group leader through the cuff ports in the cell's solid steel door. In one of her notes, Dr. Weisman observed a Trauma Group held with the youths in their cells, having to shout through their cuff port in order to participate.

3.3.5 The Relationship Between Mental Health and Corrections.

I return to what I wrote earlier (section 1.3). Intrinsically, there are two paradigms that should inform a juvenile correctional facility. The correctional paradigm centers about themes of control, discipline, and security, focused on concern with the willfulness of the youth, the fear that laxity in discipline will lead to escalating and spreading defiance. The psychiatric paradigm, on the other hand, recognizes that for behavior to improve over time, there must be a respectful engagement, an alliance, formed with the individual. There is also a willingness to look deeper into behavior, to understand what the individual experiences, what goes on in his head.

Both of these paradigms have legitimacy. A healthy environment must creatively deal with the tension between them. But in order for that to happen, they both must be empowered; they must have equal voices. This is not the case in the files I reviewed. Mental health lives in the shadow of corrections, and has been co-opted by it.

The tension between the two paradigms should especially be manifest in the disciplinary hearings, when disruptive behavior must inevitably be viewed simultaneously through both prisms. It is not. Mental health is required to comment about any mental health issues that may contribute to an understanding of why the behavior occurred, or must be considered in deciding upon the sanction to be imposed. In none of the charts does mental health advocate for a position other than punishment; in none does it seek to in any manner become an advocate for the youth, for example by participating in the

disciplinary hearing[4] Indeed, in some files, we find mental health taking on the role of corrections – prescribing punishment, including seclusion - even though mental health is aware of the multiple infirmities with which the youth is struggling.[5]
This must change. Mental Health and Corrections must have equal voices, and must be comfortable grappling with the tension that inevitably should exist between them.

4. Review of Six Mental Health Files.

4.1 C.D.

C.D. was admitted to DYS in June 2011, at the age of fifteen. He was diagnosed as having cognitive disability (his full scale IQ on admission was 42, said to be a mild – not substantial - underestimate of his abilities) and ADHD. (In addition, he was diagnosed as conduct disordered and with substance abuse; these diagnoses seem to be just about universal in the facility.) He was never diagnosed with any other condition during his DYS commitment, but somehow he ended up being prescribed at high dosage the antipsychotic/mood-stabilizing drug Seroquel – without any diagnosis that would explain its purpose.

One note in his chart stated that he had once been in "a crazy hospital", and had been in residential programs as well prior to his admission to DYS. There is no indication in the chart of any effort made to obtain those records, not even those of his psychiatric hospitalization.

As described above *(see section 3.2.2)* on arrival in DYS, C.D. was immediately placed in solitary, although he was calm, polite, and not demonstrating any risk to himself or others. Inevitably, after a few months his mental state and behavior deteriorated, and he has apparently remained in solitary confinement during either all or virtually all of his time in Scioto. And his emotional reactivity, his ability to tolerate frustration,

[4] See, for example, I.J.'s Psych File, Part 2, at 212-213; 214; 217. In some cases, the mental health staff member did not even bother to respond to the particular questions inquiring as to whether mental health issues are relevant to the behavior or to the appropriate response – e.g E.F.'s Psych File at 238.
[5] See, for example, C.D.'s Psych File, Part 2, at p21, 13, 11, 8; G.H.'s Psych File p.106, etc.

plummeted. On December 11, 2011 he was going to kill himself because he could not immediately get a drink of water. He was desperate to get his cuff port opened.

He was transferred to the Cedar Unit around the time of the reorganization. There is an August 2012 Psychological Services Summary in the chart. It is virtually word for word, grammatical mistake for grammatical mistake, identical to the one that appeared in A.B.'s chart - precisely the same "criminogenic needs" and the same "factors for success". The "first intervention employed" was identical to that in A.B.'s chart. And then "Next, the youth was seen daily …" just as in A.B.'s chart. And then the next paragraph, just as in A.B.'s chart, "These unit changes were followed by …" And then, as with A.B.: "Finally, as the Cedar Unit utilizes a focused short term …" he was promoted to Phase II and transferred to Sycamore.

Despite this cavalier use of boilerplate, there are notes suggesting that he did reasonably well during the initial 90 days he was on the Cedar Unit (February through early May 2012) before being transferred to Sycamore. It did not last, and he was back on Cedar at the end of May, in under three weeks. But once again Cedar's "short term stabilization" program "succeeded" and he was back in Sycamore in about five weeks (early July). But he lasted there only eleven days and he was back in Cedar by mid-July.

It is not clear why he did better on Cedar than on Sycamore, but he was one of the youngsters who was feeling respected during that time by staff at Cedar, and not by staff at Sycamore. The summary stated that the Cedar staff were soon going to get him back to Sycamore, but there was no attempt at a deeper understanding of this recurrent cycle of behavior. Apparently sometime in August he was again promoted to Phase II and transferred to Sycamore, but by early September he was back on Cedar Phase I, his behavior once again deteriorated.

It is not clear exactly how much he might have benefited by the treatment he was receiving on the Cedar Unit. Most of the "therapy" consisted of having him fill out

workbooks, and it is not clear whether he was motivated to do so, or even whether his cognitive difficulties would have made that a reasonable method for achieving them.

The ITP's present goals and objectives as though written by the youth *(I will identify … I will create, etc.)* But they are clearly written up by staff and many appear to be boilerplate. In many cases, they are very abstract; it is not clear that C.D. could even understand them. For example: "I will identify my personal goals and will problem solve how I can reach those goals, by: 1. I will create short term goals for myself and develop an action plan for reaching my goals … (and) 2. I will identify my values as they pertain to my life choices."

The use of workbooks appears to have been extensive. For example, one goal was to "show good physical and verbal boundaries with peers" by completing workbooks. The result was "no progress seen of yet".

Indeed, many of the goals written down in the ITP have no mention as to whether there was progress or not. In this, as in the other charts I reviewed, goals appear and disappear without comment.

4.2. G.H.

G.H. was born in 1994 and committed to DYS in September 2011. Most of the youths whose charts I reviewed had experienced violence in the community, but G.H. had experienced more than his share of violence and murder. There was a question of he being sexually abused by a cousin, and he may have been a victim of physical and sexual abuse in his neighborhood.

In addition to the usual diagnosis of conduct disorder, he also had cognitive disabilities; his IQ was measured at 67, and an OT evaluation yielded similar results. His math and reading were between a first and fifth grade level.

G.H. also suffers with serious psychiatric illness; he had been diagnosed before his commitment to DYS as having a major depression, a possible bipolar mood disorder, intermittent explosive disorder (this likely being one manifestation of an underlying bipolar disposition), and possibly also a psychotic disorder. His mother stated that he was diagnosed as having "schizophrenic tendencies"; she noted that by age 11 he was hearing voices and seeing things and was "very sad". He had been psychiatrically hospitalized as early as age ten, and had spent much time in residential treatment. He had temper tantrums, suicidal ideation, and there was a history of much self-injurious behavior; he had cut his head, stabbed himself with anything he could find that was sharp, such as a pencil point; he would sit on a hot radiator for hours until he his skin blistered. He had been on antipsychotics, mood stabilizers, and antidepressants. He had also been treated with Ritalin, a common stimulant medication used to treat ADHD. While in DYS custody, he was prescribed Ritalin; it was noted to have a calming effect, confirming a diagnosis of ADHD.

It appears that he was housed in solitary during all or almost all of his DYS confinement. There were a number of ITP's that described goals and objectives, but nothing was written about any progress. Some of the goals seemed ludicrous, well beyond his capacity to understand or apply, and so single-mindedly focused on behavior as to really be ignoring the serious mental illness that underlay and was interwoven with his behavior, for example: "I will practice rational self analysis that will help challenge the thinking that led to being put in jail".

Eventually, the clinical staff recognized that he might be better served on a mental health unit, but it is unclear whether anything was done to affect such a transfer.

4.3 A.B.

Born in January 1994, A.B. was committed to DYS in May 2011. At admission, he was on Strattera, a medication used to treat ADHD, as well as the antipsychotic/mood stabilizing medication Seroquel. Along with a strong family history of alcohol and drug

abuse, there was a history of psychiatric trouble and suicide attempts in both of his sisters. During his reception assessment interview, he was described as being "cooperative, pleasant, future oriented, with no significant cognitive or developmental issues". He was seen as a "low risk" youngster.

That optimistic picture did not last long in DYS custody. During the months after arrival, he had difficulty controlling his temper – much related to incidents of feeling disrespected or "set up" by staff - and by September 2011, he had been transferred to the PROGRESS Unit. With the 2012 reorganization, a Psychology Services Summary statement was prepared. As described before *(see section 3.3.2)* it was boilerplate – basically identical to C.D.'s. And as noted before, he was described as having done well enough to be advanced to Sycamore, Phase II, in about 21 days. It made no difference. He was in seclusion much of June and August. As indicated above, Andrea Hafner thought the "promotion" to Sycamore had little real significance. It basically changed nothing – a basically cynical attempt to demonstrate that things had changed on the PROGRESS Units.

4.4 I.J.

I.J. was only 14 when committed to DYS in August 2006. In addition to conduct disorder and substance abuse diagnoses, he was also known to have mild mental retardation; his verbal skills were at a grade 2.8, and his math skills were at a 3.9 level. He was on no psychotropic medications at reception, and a decision was made that he required no psychological services.

He did poorly in DYS custody and spent much of the time in some form of solitary confinement. After a while, diagnoses came and went. In May 2008 he was diagnosed with borderline personality disorder and a depressive disorder. Later these disappeared and were replaced in 2011 by antisocial personality disorder and "posttraumatic stress disorder by history". At that time, however, he was on two antidepressant medications, even though he no longer had a diagnosis of any form of depressive disorder. The chart

stated that "medication compliance is an issue", but it is entirely unclear whether I.J. ever was told what these medications were supposed to treat.

On April 23, 2012, he was transferred to the Cedar PROGRESS Unit as part of the reorganization. And once again, as with A.B. and C.D., a boilerplate statement was made of his endorsing the pledge, engaging fully, and being promoted to Sycamore Phase II on July 3, but he was back on Cedar within weeks.

His is a sad example of the consequences behavioral deterioration while in DYS custody. By 2012, he was seen as simply incorrigible – an antisocial personality disorder, and a misogynist. But at reception in 2006, he was described very differently, as "a cooperative youth with a euthymic mood and congruent affect." Even as late as 2009, a female OT evaluator described him as being "consistently respectful during the evaluation. … He was observed to be mannerly and respectful of staff, but does not communicate well when he is angry." But during his time in DYS custody, these better angels of his personality went into decline, and what he described as his "evil twin" gained more and more ascendance. He committed a serious assault on a staff member, and when he turned 21 in September 2012, after spending seven years in DYS custody, he was bound over to the Ohio Department of Corrections to begin serving an adult sentence for assault.

4.5 K.L.

K.L. was born in August 1992 and committed to DYS in June 2010. He is another youngster who had been diagnosed with, and treated for, serious psychiatric problems well before entering DYS. He had been psychiatrically hospitalized, and since age seven, he had been in special education due to his explosive temper and mood changes. He had also been on psychotropic medication since age seven, including both first generation and atypical/mood-stabilizing antipsychotics, as well as stimulant medication to treat ADHD. On admission, he was noted to have a bipolar mood disorder and possibly a psychotic disorder, as well as ADHD and a conduct disorder. He reported that the medication

helped "calm him down and give him time to think" – a medication response very characteristic of bipolar mood disorder.

In DYS custody, he could not control his outbursts and was mostly held in some form of solitary confinement. Dr. Alloy, his psychologist, attempted to address his problem in purely behavioral terms, as making "poor behavioral choices". He was given a CBT workbook to help him "correct" and control his outbursts. Not grasping how out of control his emotions were, or how much they would escalate, she advised him to take the option of holding his anger in for conversation later. K.L. responded by correcting her: he rejected the advice because "it would lead to bigger problems for innocent people". It is not that he did not wish he could; it was that he could not. The rage became unmanageable. And that is not to say that he did not care; he worried and feared how he would ever be able to manage his emotions and impulses. He was aware of it, fearful of it; he was watching his own mental state, how it was responding to medication; for example, in one entry he noted Geodon, the mood-stabilizing atypical/ antipsychotic he was then on, was very helpful, helping to dampen his emotional responsiveness and impulsivity.

4.6 E.F.

E.F. was committed to DYS in April 2009, just shy of turning fifteen. He had received mental health treatment prior to his commitment, but there are no releases and no reference to what occurred in those treatments.

As noted above *(see section 3.3.3)*, prior to his commitment he had been on medication for ADHD that had an important calming effect, but he was taken off it at admission without any attempt to understand what effect it actually had on him. Indeed, in September 2010, he was taken entirely off the mental health caseload.

During his commitment, it became clear that he suffered from a severe bipolar mood disorder. He manifested intense agitation and wild fluctuations in mood. His mood ranged from depressive periods during which he had feelings of doom, hopelessness

withdrawal, and intense rage, to hypomanic periods during which was voluble, excited, and positive in his outlook.

The charting and the treatment are inconsistent with each other, apparently reflecting that there was no continuity of treatment, no review of the notes that preceded a present encounter. The chart states that he was diagnosed with both Bipolar I Disorder and ADHD in April 2009. But in September 2010, he was taken off the mental health caseload altogether. He was receiving no treatment and his behavior was unpredictable and sometimes violent. He remained in solitary confinement.

In October 2011, while in seclusion, he revealed to psychologist Dr. Alloy that he was frightened of his own violent obsessional thoughts. He was afraid that he was going to kill two staff members. He felt out of control, believed he was about to do something "catastrophic" and that he was fighting against strong urges. He wanted Dr. Alloy to understand that he needed to be separated from the unit to prevent himself from doing what was on his mind. He said that a part of him understood that he was regressing back to the out of control rage he felt while confined at Ohio River JCF; he was fighting, but the bad part of him was growing and eroding away at the good part.

He was clearly frightened, and Dr. Alloy took him seriously – alerting senior staff of the danger. But there was no mental health response to this at all. It just continued. E.F. kept monitoring his own emotional state, fearful of it. In November 2011, he had visit from his biological mother that went very well; he reported that the homicidal feelings were then somewhat "dormant", "like a sleeping bear I am tip toeing around right now trying to not let it wake:.

E.F. continued expressing his fear. He told psychologist Dr. Hamning that he was afraid he would never be able to make it in a more open setting. Yet he feared that he would "lose it" if he stayed in solitary any longer. He told the doctor that he was afraid that he was genetically damaged and doomed to follow the path of his parents. He made the point that he had been in solitary for a long time without any indication of sustained

success in shedding himself of this anger, and indeed it appeared to be getting worse as he spent a longer period of time on the Cedar Unit. Dr. Hamning did nothing with this information. He made no effort to understand or connect this statement with the other statements E.F. had made regarding his fear of his own obsessional thoughts and impulses. Instead, he assessed E.F.'s statement as simply being "manipulative".

It was not until May 2012 that someone – Dr. Mak -finally recognized that E.F. was having severe psychiatric difficulties. He began E.F. on a low dose of a mood stabilizer (valproic acid) and an antipsychotic (risperdal). But there was no follow-up until July. Dr. Mak then explained to E.F. why he needed to have his blood drawn to check his valproate level, and E.F. complied. (He had refused to have his blood tested previously, apparently never having been told why it was needed.) Not surprisingly, the level was low, below therapeutic level, and Dr. Mak then doubled the dose.

But it was too late. In June, E.F. committed a violent assault against one of the DYS staff; he was charged as an adult and soon thereafter he was bound over to the Department of Corrections.

5. Conclusions.

Describing what has been occurring in the Ohio DYS as unacceptable or unconstitutional does not fully capture the experience of reading the youths' files. It is tragic. I was provided six charts, and every one of them demonstrated the destructive impact of their confinement at ODYS. Youths arrive with severe psychiatric and cognitive burdens, but they arrive with some hope, some willingness to engage. Placing this exquisitely vulnerable group of youngsters in harsh conditions of solitary confinement basically dooms them. They become more violent, more out of control, more rigidly locked into their "evil side". One wonders whether DYS has in reality doomed those youngsters. Two of the six youngsters whose chart I reviewed eventually while in DYS custody committed an assault resulting in their being transferred to an adult prison. But even for

the others – all those years when their brain development should be consolidating social, educational, and occupational domains, when they should be developing the capacity for emotional modulation and impulse control - will they ever be able to recover what they have lost? How disabling will be the developmental distortions they have experienced? DYS custody has not resulted in treated and rehabilitation; it may well have permanently crippled them.

In one of their defenses to the plaintiff's allegation, the ODYS claimed that:

> The agency already thoroughly screens youth prior to placement on the PROGRESS Unit. Aaron Bauer reviews each application for placement, and Dr. Dachowski looks for contraindications for all youth on the mental health caseload. Youth who engage in violent behavior related to cognitive limitations or mental illnesses are sent to the Life Skills Unit or Mental Health Unit. (Laura Dolan, Aaron Bauer) Youth who are placed on PROGRESS have higher levels of aggression and manipulative behavior. The application and screening process for PROGRESS is to distinguish between those whose disruptive behavior is a conscious choice and those who behaviors are related to their mental health diagnoses.

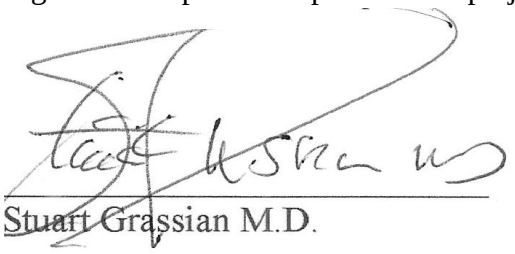
If the file reviews above demonstrate anything, it demonstrates that there is no truth at all in this statement. Every one of the six youths had major psychiatric and/or cognitive disabilities.

How could this be? Ultimately, it is because mental health has very little say in what happens in ODYS, and there is no will to look or think deeply. Charts are chaotic. Diagnoses come and go. Behavioral manifestations of psychiatric illness and of the erosive effects of solitary confinement are viewed as "conscious choices" and "thinking errors", cognitive distortions that must be corrected. It is easier to just stop at the surface – to look only at behavior and to conceptualize it as under rational control. Although there truly are examples in the chart of caring, helpful clinical interactions, overall the charts reveal an attitude of cynicism – treatment plans that are just boilerplate, almost identical for each youth, chaotic charting that basically ensures that there will be no deeper examination of the underpinnings of behavior.

In justifying their use of the PROGRESS units as "treatment" –"programming", they attempt to describe it as a form of behavior modification treatment using aversive conditioning (that is, do something bad, something bad happens to you). But it simply is not. First of all, it assumes that the object of the behavioral scheme is a rational actor – one who will respond to a rational calculus of means and ends, rewards and punishments. These youth are most often simply incapable of responding to such a rational calculus; they are too impulsive, to locked into their emotion of the moment. And secondly, for any behavior modification scheme to work, it must provide frequent opportunities for reward or punishment, and those rewards or punishments must come quickly after the behavior at issue. None of this is consistent with the DYS PROGRESS UNIT program. The phase system itself disconnects for at least several weeks good behavior from any positive result.

ODYS has the responsibility to protect and rehabilitate youth, to help them develop into functioning adults. Instead, it embraces the worldview of harsh punishment, of pounding, never-ending deprivation. It breeds cruelty and dehumanization, as bad or even worse than that found in many adult prisons. Over time, the disciplinary sanctions so freely prescribed grow to a point that they are mountainous, and there is nothing left in the youth besides hopelessness and rage. The PROGRESS UNIT program destroys what it is supposed to nurture.

Signed under pains and penalties of perjury, October 23, 2012.



Stuart Grassian M.D.

Attachment C

The following documents were examined in the development of this affidavit:

- Requested files for 6 SMU youth:
  - Movement screens
  - Reception Assessment Summaries
  - Referral Fact Sheets
  - Institutional Transfer Notices of Approval
  - SMU Admission tool
  - SAVRYs
  - Strategies for Success Plan
  - Structured Assessment Summary
  - MH Diagnoses
  - Psych summary forms
  - Psych summaries
  - Psychology files
  - Psychiatric progress notes
  - Psychiatric Evaluations
  - Medical files
  - Behavioral Health Transfer Fact Sheet
  - Behavioral Health Appraisal
  - Occupational Therapy Evaluations
  - Individualized Treatment Plans
  - Goal sheets
  - Interdisciplinary Team Progress Reports
  - Incident reports and related medical assessments and photographic evidence
  - Intervention hearing packets, notifications, reports, and dispositions
  - Grievances
  - Attendance screens
  - Attendance behavior reports
  - Evaluation Team Reports
  - Individualized Educational Plans
  - Behavior logs
  - GED certificates
  - Scioto County Journal Entries
  - JJCMS Release Authority Discharge Review
  - Letters from Release Authority
  - Progress Review Summaries after each meeting with Release Authority
  - JCCMS Reentry Letters
  - Presumptive Release Discharge
  - Various letters, memos, and email exchanges
- Handwritten and recorded logs showing in and out of room time and programming for all PROGRESS youth
  - Sycamore Unit: June 18 – July 18, 2012
  - Cedar Unit: June 18 – August 27, 2012
- S.H. Stipulation Agreement (April 3, 2008)
- Third Annual Report of the Monitor

- Third Annual Report Final Supplement
- SJCF Mental Health Expert Report (January 2012)
- SJCF Safety, Management, and Programming Expert Report (February 2012)
- Letter from Plaintiffs' Counse RE: PROGRESS Units at Scioto (June 26, 2012)
- SOP 301.05.03: Seclusion Reporting, Monitoring, and Documentation Requirements
- SOP 301.05.07.A: PROGRESS Admission Tool
- SOP 301.05.07.B: SJCF PROGRESS Unit Weekly Checklist
- SOP 301.05.07.C: PROGRESS Unit Request – PROGRESS Referral Fact Sheet
- SOP 301.05.07.D: PROGRESS Unit Documentation Checklist
- SOP 301.05.07.E: Behavioral Health Services Mental Status Report
- SOP 301.05.07.F: ODYS SJCF Unit PROGRESS Handbook
- SOP 303.01: Youth Rules, Interventions & Incentives
- SOP 303.01.01: Rules of Youth Conduct
- SOP 303.01.02: Youth Intervention Sanctions
- SOP 303.01.02.B: Behavioral Interventions Grid
- SOP 303.01.03: Youth Intervention Hearings
- SOP 303.02: Individual Response to Acts of Violence (IRAV) – Seclusion Assessment Process
- SOP 303.02 with Comments from Plaintiffs' Counsel
- SOP 303.02.A: IRAV Seclusion Assessment
- SOP 303.02.A with Comments from Plaintiffs' Counsel
- IRAV Seclusion Assessment Appendix B: Validation and Evaluation
- IRAV Seclusion Assessment Final Pilot Validation & Evaluation Report
- IRAV Seclusion Assessment Operations Manual
- Draft of SOP 303.01.07: Unit PROGRESS (July 6, 2012)
- Letter from Plaintiffs' Counsel in Response to SOPs (June 26, 2012)
- Memo from Monitor to Amy Ast Re: Revised PROGRESS Unit SOP (July 18, 2012)
- DYS Seclusion Hours Brief (July 17, 2012)
- Youth Declarations (July 2012)

Stuart Grassian, M.D.
401 Beacon Street
Chestnut Hill, MA 02467-3976
Phone (617) 244-3315 Fax (617) 244-2792
stgrassian@aol.com

Born: June 29, 1946

EDUCATION, TRAINING, FACULTY POSITIONS.

1963-1967	Harvard Club Scholar, Harvard University, Cambridge, MA
1967	B.A. Cum Laude, Harvard University, Cambridge, MA
1967-1969	NIMH Fellow in Sociology, Brandeis University, Waltham, MA
1969	M.A., Sociology, Brandeis University, Waltham, MA
1970	NSF Fellow in Psychiatry, Bellevue Hospital, NY
1973	M.D., New York University School of Medicine, NY
1973-1974	Intern (Medicine), New York University Medical Center, NY
1974-1977	Resident in Psychiatry, Beth Israel Hospital, Boston, MA.
	Teaching Fellow in Psychiatry, Harvard Medical School.
1977-2003	Clinical Instructor in Psychiatry, Harvard Medical School.
1978-1980	Assistant Clinical Professor of Psychiatry, Tufts University School of Medicine.
1982-1986	Suffolk University Law School; J.D. 1986; Daniel Fern Award.
1986	Bar Examination completed; entry into Massachusetts Bar.(remain on "retired"
status	through present.)

LICENSURE.

1974-	Massachusetts Medical License #37749.

BOARD CERTIFICATIONS

1979	Diplomate, American Board of Psychiatry and Neurology (ABPN) in Psychiatry.
1994	Diplomate Certification, ABPN, Added Qualifications in Addiction Psychiatry.
1996	Diplomate Certification, ABPN, Added Qualifications in Forensic Psychiatry

MAJOR PROFESSIONAL ACTIVITIES

1977 -	Private practice in Psychiatry: Cambridge, MA (1977-1979), Chestnut Hill, MA (1979-), Stoneham, MA (1980-2003)
1977-1978	Clinical Director, Inpatient Service, Dorchester Mental Health Center, Boston, MA
1978-1980	Director, Inpatient Service, WestRosPark Mental Health Center, Boston, MA
1979-1983	Medical Staff, Lecturer, Glover Memorial Hospital, Needham, MA
1980-1994	Attending Psychiatrist, Adult & Adolescent Inpatient Services, New England Memorial Hospital, Stoneham, MA
1980-1983	Director, Adult & Adolescent Inpatient Services, Department of

	Psychiatry, New England Memorial Hospital, Stoneham, MA
1983-1994	Attending Psychiatrist, Addictions Treatment Unit, New England Memorial Hospital, Stoneham, MA
1987-1993	Supervising Psychiatrist, Outpatient Department, New England Memorial Hospital, Stoneham, MA
1992-1994	Psychiatric Director, Partnership Recovery Center, Melrose-Wakefield Hospital, Melrose, MA (Day treatment program for Addiction rehabilitation)

CONSULTATIONS, AFFILIATIONS, BOARD MEMBERSHIPS

1979-	Massachusetts Correctional Legal Services. (Psychiatric Effects of Solitary Confinement, Psychiatric Effects of Strip Search Procedures)
1980-	Massachusetts Civil Liberties Union. (Psychiatric Effects of Strip Search Procedures, Psychiatric Effects of Solitary Confinement)
1993-	Massachusetts Department of Corrections, Stress Management Unit. (Occupational Stress among Correctional Staff)
1993-4	Board of Trustees, New England Memorial Hospital, Stoneham, MA.
1995	Consultation to Psychiatric Expert/Special Master; Madrid v Gomez Federal District Court, Northern District, CA #C-90-3094TEH. (Psychiatric Effects of Solitary Confinement)
1995-	Consultant to Massachusetts Professional Recovery Committee, and to Substance Abuse Rehabilitation Program of the Massachusetts Board of Registration in Nursing. (Addictive Disorders, Impaired professionals)
1997	Botech Corporation, Cambridge, MA. (Effects of Solitary Confinement)
1998	Psychiatric Expert in Compliance Monitoring; Eng v Coombe Federal District Court, Western District, NY, CIV #80-385-S. (Effects of Solitary Confinement)
2000-2	The Desisto School, Lenox MA
2001-	Consultant, Florida Department of Corrections. (Solitary Confinement and Mental Health Issues in Florida State Prisons.)
2001-	Board of Advisors, Correctional Association of New York, (Mental Health Issues in New York State Prisons).
2002-4	Board of Directors, Massachusetts 9/11 Fund.
2002-4	American Boyschoir School, Princeton, NJ.
2002-3	Poly Prep School, Brooklyn, NY.
2009.	U.S. Department of Defense, Office of Military Commissions. Effects of Confinement on Guantanamo Detainees, Arlington, Va,.
2010	Texas ACLU. Expert in K.C. v. Townsend, challenging conditions in state's xsadolescent female detention facility.
2012-	Advisory Committee. New York State Commission on Quality of Care and Advocacy for Persons with Disabilities (CQCAPD) .

(Note: As a result of my experience with the effects of stringent conditions of confinement, I have had a large number of other affiliations and consultations, which have not been separately listed. The following is not a complete list: American Friends Service Committee, Amnesty International, The Capital Habeas Unit of the Defender Services Division of the United States Courts, The Center for Constitutional Rights, The Correctional Association of New York, Federal

Public Defender - of E. Dist VA, of Tennessee, of the State of Washington, and of Washington, DC, The Legal Aid Society of New York, National Defenders Investigators Association, The National Prison Project of the ACLU, Prisoners Legal Services of Michigan, of New Mexico, and of New York, Public Defenders Office of Connecticut, and of Maine, etc.)

PROFESSIONAL SOCIETY/COMMITTEE/STAFF MEMBERSHIPS

1974-2003. Member, American Psychiatric Association &
Massachusetts Psychiatric Society
Committee Memberships.
Inpatient Psychiatry Committee (1981-1984)
Private Practice Committee (1992-1995)
Chair, Presidents Task Force on Managed Care (1993-1994)
Steering Committee, Managed Care Retreat (1993-1994)

1974-1977 Resident in Psychiatry, Beth Israel Hospital, Boston, MA.
Clinical Fellow in Psychiatry, Harvard Medical School.

1977-2003 Courtesy Staff, Beth Israel Hospital, Boston, MA
Assistant in Psychiatry (1977-1991)
Associate in Psychiatry (1991-2003)
Clinical Instructor in Psychiatry, Harvard Medical School.

1980-1999 Active Staff, Boston Regional Medical Center, Stoneham, MA
Committee Memberships
Credentials Committee (1986-1990)
Chair, Bylaws Committee (1987-1990)
Medical Staff Executive Committee (1989-1992)
Chief of Staff (1990-1992)
Board of Trustees (1990-1992)

1992 - Active/Courtesy Staff, Melrose-Wakefield Hospital, Melrose, MA

1993-2000 Psychiatric Network of Massachusetts
Committee Memberships
Steering Committee (1993-1994)
Chairman, Board of Directors (1994-1995)

AWARDS

2005. National Alliance for the Mentally Ill (NAMI). Exemplary Psychiatrist Award, Presented at Annual Meeting, American Psychiatric Association, May 2005.

TEACHING APPOINTMENTS, PRESENTATIONS

1967 Teaching Fellow, Harvard Graduate School of Education, Cambridge, MA

1967-1969 Teaching Fellow, Department of Sociology, Brandeis University, Waltham, MA

1973 Clinical Fellow in Psychiatry, New York University Medical Center, New York, NY

1974-1977 Clinical Fellow in Psychiatry, Harvard Medical School, Boston, MA

1975-1976	Consultant and Lecturer, Human Resources Institute, Brookline, MA
1977-2003	Clinical Instructor, Department of Psychiatry, Harvard Medical School, Boston, MA
1978-80	Assistant Clinical Professor, Department of Psychiatry, Tufts University Medical Center, Boston, MA
1987	Faculty, Third International Conference on Restricted Environmental Stimulation, New York, NY: "Effect of REST In Solitary Confinement and Psychiatric Seclusion"
1987	Guest Lecturer, Suffolk University School of Law, Boston, MA: "Commitability and the Right to Refuse Treatment"
1988	Faculty, 32nd Institute on Hospital and Community Psychiatry, Boston, MA
1990	Massachusetts Bar Association Symposium, Boston, MA: "Drugs and Alcohol on Campus"
1992 -	Faculty, American Academy of Psychiatry and Law, Boston, MA: "Effects of Childhood Sexual Abuse"
1993	Faculty, Massachusetts Department of Corrections Stress Unit, Statewide Seminar, MA: "Stress Awareness for Managers"
1993	Massachusetts Continuing Legal Education Seminar, Boston, MA: "Psychiatric Effects of Physical and Sexual Assault"
1994	Massachusetts Academy of Trial Attorneys Seminar, Boston, MA: "Psychiatric Evaluation of Victims of Violent Crime"
1994	Beth Israel Hospital/Harvard Medical School, Boston, MA: "Psychiatric Consequences of Solitary Confinement; "Effects of Sensory Deprivation and Social Isolation in a Vulnerable Population"
1994	Massachusetts Medical Society, Committee on Managed Care, Waltham, MA: "Ethics of Managed Care"
1994	Prison Psychiatric Group, Albany, NY: "Criminality and Mental Illness, Revisited: Disorders of Volition". (Lecture sponsored by Pfizer Pharmaceuticals)
1995	Suffolk University Advanced Legal Studies, Boston, MA: "Sexual Abuse: Memory, Truth and Proof"
1995	Massachusetts Association of Trial Attorneys Seminar, Boston, MA: "Premises Liability/Negligent Security: Psychiatric Testimony and the Role of the Psychiatric Expert"
1996	New England Society for the Study of Dissociation, McLean Hospital, Belmont, MA: "Impact of Forensic Issues on Treating Victims of Violence"
1996	Harvard Medical School, Children's Hospital Family Violence Seminar, Boston, MA: "Trauma and Memory"
1996	Trauma and Memory: An International Research Conference, Durham, NH: "Factors Distinguishing True and False Memory of Childhood Sexual Abuse"
1996	Trauma and Memory: An International Research Conference, Durham, NH: "Memory of Sexual Abuse by a Parish Priest"
1997	Correctional Association of New York, NY: "Psychiatric Effects of Solitary Confinement".
1998	Massachusetts Board of Registration in Medicine and Northeastern University Conference, Substance Abuse and

The Licensed Professional, Boston, MA: "Addictions and Compulsions: Disorders of Volition"

2000 Human Rights Watch and American Civil Liberties Union Foundation Conference. Washington, D.C. "Super-Maximum Security Confinement in the United States."

2003 Capital Habeus Unit Training Conference of the Defender Services Division of the United States Courts, San Antonio, TX. (lecture regarding death row confinement and its effects on post-conviction appeal process.)

2003 NAACP Legal Defense Fund Conference, Airlie, VA. 7/03. Lecture regarding mental health issues and solitary confinement of prisoners.

2005 Vera Institute. National Commission on Safety and Abuse in Prisons. Newark NJ, July 2005. Effects of Isolation.

2005. NAACP Legal Defense Fund, Airlie Conference, Va. July 2005. "'Volunteers' in Death Row".

2006 University of California at Davis, Symposium - The Neurobiology of Torture. "What is Known about the Neurobiological Effects of Solitary Confinement."

2009 Keynote Address. Nova Scotia Barristers' Society. "Psychiatric Effects of Solitary Confinement".

2010 "Psychiatric Effects of Solitary Confinement". Presentation at Virginia Bar Association Meeting, Richmond, VA.

2010 Harvard Prisoners Legal Assistance Project. Invited lecture regarding psychiatric effects of confinement and impact on advocacy.

2010 Discussant, Symposium at Annual Meeting of American Psychological Association, San Diego, CA. "One Year Longitudinal Study of the Psychological Effects of Administrative Segregation."

2012 Civil Rights Committee, New York State Bar Association. "Psychiatric Effects of Solitary Confinement".

2012 Columbia University, "Incarceration and Isolation: A Workshop". Joint Meeting with the Liman Public Interest Program at Yale Law School, and the Lowenstein International Human Rights Clinic at Yale Law School

MEDIA, PUBLIC AFFAIRS PRESENTATIONS

1988 NBC-TV, Today Show "Small Group Confinement of Female Political Prisoners at the Federal Penitentiary in Lexington, KY"

1990 NPR-TV, News Interview Program: "Psychiatric Effects of Small Group Confinement"

1990 PBS-TV, Point of View "Through the Wire", Documentary regarding women confined for politically motivated crimes

1991 WBZ-TV, Boston, MA: Channel 4 Nightly News "Statute of Limitations on Cases of Childhood Sexual Abuse"

1992 Boston Globe, New York Times, etc.: "Effects of Childhood Sexual Abuse by a Catholic Priest"

1992 Boston Globe, New York Times, San Francisco Chronicle, Los Angeles Times, etc.: "Psychiatric Effects of Solitary Confinement"

1993 New England Cable News, Newton, MA: Commentator regarding

insanity defense in Kenneth Sequin trial
1993 Massachusetts House of Representatives, Judiciary Committee testimony: Proposed change in Statute of Limitations in cases of childhood sexual abuse
1993 CBS-TV, 60 Minutes "Pelican Bay – Psychiatric Effects of Solitary Confinement in California's High-Tech Maximum Security Prison"
1993 New England Cable News, Newton, MA: News Night "False Memory and Recovered Memory of Childhood Sexual Abuse"
1993 WCVB-TV, Boston, MA: Chronicle "Sentencing of Father Porter – The Effect on the Victims"
1994 WHDH-TV, Boston, MA: Boston Common "False Memory Syndrome".
1994 FOX-TV, Boston, MA: At Issue "Psychiatric Effects of Solitary Confinement"
1996 New England Cable News, Newton, MA: News Night "The Insanity Defense"
1998 ABC-TV, Nightline with Ted Koppel; Primetime Live "Crime and Punishment"
1998 WBZ-TV, Boston, MA: Channel 4 Nightly News "Perpetrators of Sexual Abuse: Dangers to the Community"
1999 ABC-TV, 20/20 "Effects of Solitary Confinement"
2003 Discovery Channel. "Mohammed Atta: Profile of a Terrorist".
2003 Invited Testimony, Joint Legislative Hearing, New York State Assembly, New York City, November 2003. "Disciplinary Confinement and Treatment of Prison Inmates with Serious Mental Illness."
2004 Invited Testimony, Massachusetts State Legislature. Joint Committee on Public Safety. "The Cost of Corrections".
2010 Invited Testimony, Maine State Legislature: "Solitary Confinement in Maine."
2010 National Geographic Television: "Explorer: Solitary Confinement".
2011 National Religious Campaign Against Torture. "Solitary Confinement".

(Due to the extensive public interest in the issue of solitary confinement, I have also provided interviews and contributions to a number articles in various newspapers, magazines, and radio and television news reports and documentaries; I have not been able to keep up a catalogue of these, though they certainly include The Boston Globe, The New York Times, The Los Angeles Times, The San Francisco Chronicle, The Denver Post, New Yorker Magazine, and National Public Radio, as well as others.)

MAJOR INTERESTS IN FORENSIC PSYCHIATRY

1. <u>Psychiatric Effects of Solitary Confinement</u>

I have had extensive experience in evaluating the psychiatric effects of stringent conditions of confinement, and have served as an expert in a number of both individual and class-action lawsuits addressing this issue. My observations and conclusions regarding the psychiatric effects of such confinement have been cited in a number of federal court decisions, for example: *Davenport v. DeRobertis*, 844 F.2d 1310 (7th Cir. 1988), and *Madrid v. Gomez*, 889 F. Supp. 1146 (N.D. Cal. 1995).

I prepared a written declaration for *Madrid* describing the medical literature and historical experience concerning the psychiatric effects of restricted and isolated conditions of confinement as well as of other conditions of restricted environmental and social stimulation, and subsequently prepared the general (non-institution specific) and non-redacted (non-inmate specific) portions of that declaration into a general statement, which I have entitled *Psychiatric Effects of Solitary Confinement*, 22 Wash. University Journal of Law and Policy, (2006). It describes the extensive body of literature, including clinical and experimental

literature, regarding the effects of decreased environmental and social stimulation, and more specifically, observations concerning the effects of segregated confinement on prisoners.

I have given lectures and seminars regarding this issue. Although I do not have a complete list of those lectures and seminars, they include, but are not limited to, lectures at Harvard Medical School-Beth Israel Hospital, Boston, at meetings of the Nova Scotia and of the Virginia Bar Associations, The Office of Military Commissions of the U.S. Department of Defense, The Federal Capital Defenders Habeas Unit and The Correctional Association of New York, as well as, invited testimony before state legislative hearings in New York, Massachusetts and Maine. In January 2012, I will be addressing this issue at the New York State Bar Association. In addition, I was recently appointed as a consultant to the Psychiatric Correctional Advisory Committee of the New York State Commission on Quality of Care and Advocacy for People with Disabilities

I have been retained as an expert in class-action lawsuits regarding these issues in Massachusetts (2), New York (3), California (2), Kentucky, Michigan, Ohio, Texas and Florida, as well as individual cases in other states, including California, Connecticut, Florida, Georgia, Maine, Massachusetts, New Mexico, New York, Pennsylvania, Texas, Virginia and the State of Washington. I have been retained and consulted by a variety of public advocacy groups, including The Legal Aid Society of New York, Prisoner's Legal Services of New York, the Center for Constitutional Rights, The Massachusetts Correctional Legal Services, The Massachusetts Civil Liberties Union, the National Prison Project of the American Civil Liberties Union, and the Department of Corrections of the State of Florida. Since the tragic events of September 11, 2001, I have also been consulted regarding the confinement of a number of individuals who were deemed to be "enemy combatants" and/or were either charged with or convicted of conspiring against the United States. These include individuals who were confined in Guantánamo, in the Navy Brig in Charleston, S.C., in the Federal ADX prison in Florence, Colorado and in the SeaTac facility in Seattle, Washington, as well as in federal detention centers in New York City and Miami, Florida. Decisions in some of those cases, and my published findings, have been cited in Federal Appellate decisions, and have also generated significant national media interest.

Issues have included: mental illness among inmates so confined; effect on ability to assist in inmate's own legal defense (both pretrial and postconviction); "volunteering" for execution; impact on inmate's ability to cooperate with government in debriefing and testifying. Additionally, have been consulted in a number of cases involving detention (at Guantanamo, Charleston S.C. Naval Brig, and various Federal Detention Centers) of accused terrorists

Peer-Reviewed Medical Publications:
"Psychopathological Effects of Solitary Confinement", Am J Psychiatry 140:11, 1983.
"Effects of Sensory Deprivation in Psychiatric Seclusion and Solitary Confinement", Intl J Law & Psychiatry 8:49, 1986.

Law Journals:
"Psychiatric Effects of Solitary Confinement", Washington Univ. Journal of Law & Policy Vol 22: pp. 325-383, 2007.

Book Chapter:
"Neuropsychiatric Effects of Solitary Confinement" in Ojeda, ed., The Trauma of Psychological Torture, Praeger, Westport Conn., 2008.

On-Line Publications:
"'Fatal Flaws' in the Colorado Solitary Confinement Study". In Solitary Watch; Posted November 15, 2010

Attachment C

2. Strip Search Procedures, Sexual and Physical Assault

Psychiatric expert in a number of strip search cases in Federal and Massachusetts state courts. Testimony has been cited by the Federal Appeals Court in Cole v Snow. Consulted in settlement of three class action suits.

Psychiatric expert in cases of rape, sexual and physical assault. Substantial experience in evaluating the effects of childhood sexual abuse, and the processing over time of memories of that abuse. Evaluated approximately 100 victims of childhood sexual abuse, including many of the plaintiffs in the clergy sex abuse scandals in Massachusetts. Consulted to private schools around such issues.

Research and Presentations:

Principal Investigator, Beth Israel Hospital, Department of Psychiatry, Boston, MA.
"Psychiatric and Addictive Problems in Survivors of Childhood Sexual Abuse Perpetrated by Father Porter."
"Recovery of Memory of Childhood Sexual Abuse and Creation of False Memories; Can These Processes be Distinguished?".

3. Addictive Disorders

Testimony in a number of criminal and civil cases. My testimony in a highly publicized case, In re Cockrum, helped to establish that an individual who was otherwise highly competent, was not competent to act in his own behalf in appealing his murder conviction, as a result of an underlying addictive suicidal compulsion.

4. Civil Rights Issues

Expert in a number of cases regarding racial and sexual harassment in employment and housing situations, including cases brought by Civil Rights Division of the United States Department of Justice, and by Greater Boston Legal Services, and in strip search procedures by law enforcement and prison personnel.

(updated 12/10/11)