UNITED STATES DISTRICT COURT
WESTERN DISTRICT OF MICHIGAN

MICHIGAN PROTECTION & ADVOCACY SERVICE, INC.,

Plaintiff,

v

PATRICIA L. CARUSO, in her official capacity as Director, Michigan Department of Corrections,

Defendant.

Case No. 5:05-CV-0128

Hon. Richard Alan Enslen

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SETTLEMENT CONFERENCE REPORT OF JOEL DVOSKIN, PH.D. IN ACCORDANCE WITH ORDER OF SEPTEMBER 22, 2006

In an Order following the September 15, 2006 Settlement Conference in this matter, the Court directed me to file a written report "regarding [my] recommendations, including various MDOC facilities, within 30 days" of the Order. I am pleased to do so.

I understand that this Report is for settlement purposes and is intended to assist the parties and the Court in their further discussions in an effort to resolve the matter without trial. Accordingly, I have not drafted the Report with the formalities required by the Federal Rules of

Civil Procedure, Rule 26(a)(2)(B). I have, however, attached my *curriculum vitae* for the information of the Court and the Defendant.

I caution the parties and the Court that I have not yet engaged in the full and complete examination and investigation that I would undertake before submitting a formal report and before testifying. For example, I have not undertaken a full review of inmates' records, something that I might later determine is necessary. Likewise, I recognize that I have visited only three of the State's facilities, and I have not conducted extensive interviews of inmates and staff members. Thus, the opinions expressed here (that are the same as those I presented at the settlement conference) are based on my review of the pleadings, certain inmate information provided to me by the Plaintiff's counsel, MDOC policies also provided by counsel, tours of three prisons, interviews with prison staff and administrators, brief discussions with segregated inmates during the tours, and out-of-cell interviews with 13 youthful inmates. Therefore, although the review I have conducted to date provides a sufficient basis upon which to form the opinions I relate here, it is possible that upon further investigation I might alter, revise, or supplement them.

Finally, a few words about the limitations of my investigation are necessary. First, I have not been asked to and do not address the Plaintiff's education related claims, except in a limited manner and as they relate to youth in segregation. Second, although I saw and spoke with inmates of all ages, consistent with the claims in the case, I concentrated on inmates under the age of 26. All of my confidential out-of-cell inmate interviews were with inmates under 26 years old.

1. The tours.

I toured three MDOC facilities during the week of September 11, 2006. I visited the Bellamy Creek Correctional Facility, a Level 2 and 4 facility, in Ionia on September 12, 2006; the Thumb Correctional Facility, a Level 2 facility with a program for youthful offenders in Lapeer, on September 13, 2006; and, Standish Maximum Correctional Facility, a Level 5 facility, on September 14, 2006. Each of the tours included meetings with facility administrators, a tour of the facility (with an emphasis on living quarters and segregation and isolation units), and confidential interviews with youthful inmates identified by the Plaintiff. The Bellamy and Thumb visits began at 9:00 AM and concluded after 4:00 PM. The Standish tour began at 11:00 AM and concluded at about 3:30 PM. We did not break for lunch or for any other purpose at any of the facilities.

At each of the facilities, Plaintiff's counsel accompanied me. Defendant's counsel, Assistant Attorney General Leo Freidman, was present at each of the facilities as was Steven Meno, a representative of the Corrections Mental Health Program ("CMHP") of the Department of Community Health ("DCH"), the agency that is responsible for the "outpatient mental health" services at the prisons. Roy Calley, the CMHP Director, joined us at The Thumb. At each facility, the warden, deputy warden, and/or an assistant deputy warden and other staff were also present. In all cases, the staff and administration were very cooperative with the tour and were responsive to my inquiries. As I said at the settlement conference, I particularly found the wardens I met to be highly professional. I appreciated their cooperation and assistance.

2. Mental health services at the facilities.

Bellamy Creek and the Thumb divide their mental health services into two teams. The MDOC operates Psychological Services Units ("PSUs") that are designed as "gatekeepers," that

is, to identify mentally ill, developmentally disabled, and other special needs prisoners for referral to the Outpatient Mental Health Team ("OPMHT"). I was told that prisoners with major mental illnesses are appropriate for such referral. Some PSU staff also deliver some group therapy and offender rehabilitation programs such as assaultive offender and sex offender groups.

There is also a "gate keeping" function of sorts at the intake or reception center at Jackson. However, both staff and inmates described inadequacies in the testing and evaluation there and said that some inmates with mental disabilities, particularly some with developmental disabilities, are not identified.

The OPMHT is operated by DCH's CMHP under a contract with MDOC. I was told that the OPMHT is an interdisciplinary team that provides mental health services to prisoners with major mental disorders. Depending on the facility, the OPMHT may include one or more nurses, a part-time or full-time psychiatrist, one or more psychologists (I do not know the educational level of the psychologists), and one or more social workers.

At least at Bellamy Creek, nurses on the health care services team administer medications, including psychiatric medications. I understand the health services to be delivered under a contract with Correctional Medical Services, Inc. I assume this is also true at the other facilities.

Standish, the maximum-security facility, does not have an OPMHT and has only one psychologist on its PSU. I was told that any inmates identified by the PSU psychologist as needing outpatient treatment are transferred to other Level 5 facilities (for example, Ionia Maximum) that have OPMHTs.

I was told that if the OPMHT believes that an inmate needs secure inpatient mental health care (higher level of care than can be provided by the OPMHT), he may be transferred to a Residential Treatment Program ("RTP") at either Ionia (apparently Riverside Correctional Facility) or the Huron Valley Center. I was told that acute mental health inpatient care is provided at Huron Valley and that there is a six-bed crisis intervention unit at Riverside Correctional Facility, Ionia.

3. Segregation

Each of the facilities uses segregation in three forms: disciplinary segregation, administrative segregation, and protective custody. All three may be used regardless of the inmate's age. The Thumb also has an apparently unique Behavior Modification Unit ("BMU") in its Program for Youthful Offenders. This program, also apparently called the HOPE program, is described in the next section of this report.

Segregation units are separated from the general population housing units. As I came to understand it from my tours and my review of MDOC policies, disciplinary segregation is used as punishment for major misconduct rule infractions (called "tickets" or "major tickets" by staff and inmates alike) and in such cases inmates have the right to a hearing. Prior to this, an inmate may be placed in temporary segregation pending a hearing. After a hearing, the inmate may be sentenced to disciplinary segregation for up to 30 days for each offense, or 60 days for all violations arising from a single incident. An inmate's prior disciplinary history (including, for the young inmates who are the subject of this case, tickets that obtained at the now closed Michigan Youth Correctional Facility, "MYCF") is a factor in determining placement in disciplinary segregation.

Upon completion of the term of disciplinary segregation, an inmate may be placed in administrative segregation, apparently at least initially without a hearing. (This process was not entirely clear to me.) Administrative segregation is used for those inmates that the warden, deputy warden, or shift supervisor determines to meet at least one of the following criteria: 1) They have demonstrated an inability to be managed with the general population; 2) They present a serious threat to the physical safety of staff or other prisoners or to the good order of the facility; 3) They present a serious escape risk; or 4) For other reasons, they are not appropriate for the general population. A deputy superintendent reviews each inmate's status in administrative segregation once a month. Protective custody is used, sometimes at the request of the inmate and in other cases involuntarily, to provide protection from others.

Disciplinary and administrative segregation are the most restrictive levels of security classification, and during my tour they were sometimes referred to as "Level 6."

There is little if any difference from facility to facility (at least those I toured) in the physical conditions in which inmates on the several forms of detention are housed. Their cells are small (approximately 6 feet by 9 feet), with a heavy steel door, little natural light, a small window to the corridor, and a food port. Oral communication with custody, health, mental health staff, and chaplains is typically through the food port or at cell front. There is little or no privacy possible in such interactions.

Though they can communicate (e.g., by yelling) with other segregation inmates, inmates in segregation are deprived of virtually all normal social contact and environmental stimulation. They are allowed no congregate activity and very few possessions. Recreation time is limited to one hour a day in small specially designed secure outdoor space that prevents direct contact with other prisoners. Otherwise, except in very limited circumstances (e.g., attorney visits, periodic

showers), segregated inmates are confined to their cells 23 hours a day. Ironically, programs such as "assaultive groups" are not available to inmates in segregation, many of whom are there because of assaultive behavior.

There are no levels in disciplinary or administrative segregation and, therefore, no way for one to earn increased freedom, possessions, or privileges gradually by demonstrating the ability to manage their behavior appropriately. Nor is there any incentive for appropriate behavior, except the vague and uncertain possibility that they might be returned to general population. (As described below, the adolescent program at the Thumb does employ a graduated type of segregation in the BMU.)

Many of the inmates I saw in the segregation units were on their bunks, apparently asleep. Some of the concrete beds were equipped with braces to which mechanical restraints may be attached. I was told this procedure is called "top of bed" restraint. The units, particularly the one at Standish, were very noisy.

Practices appeared to vary as to how often segregated inmates are seen by the PSU or the OPMHT. For instance, at Bellamy Creek the PSU sees everyone only after they have been in segregation for 30 days, unless a specific referral is made earlier. Inmates invariably told me that the PSU visited less often than staff said they did. Inmates described the visits, when they happened, as perfunctory. Several inmates said that their kites for mental health services were ignored or that it took days or weeks for PSU to see them. Although OPMHT may see a segregated inmate privately outside the cell, alleged or perceived security concerns appear to make this an infrequent occurrence.

Young inmates with whom I spoke told me that they had very few educational opportunities while in segregation. Although I did see one teacher talking to an inmate through

his food port, there was very little evidence that segregated inmates with special or regular educational needs receive much more than very perfunctory educational instruction while in segregation. Several inmates stated that a teacher would merely "drop off" homework and then leave after a very brief discussion.

4. The Program for Youthful Offenders at the Thumb.

The Program for Youthful Offenders ("PYO") at the Thumb, I was told, was created to accommodate youth between ages 14 and 26 who were transferred to The Thumb when the Baldwin facility (the Michigan Youth Correctional Facility) was closed, after the filing of this case. The Thumb is a Level 2 facility. As I understood it, youth at Baldwin who were under 17 and had special education needs or were on the OPMHT at Baldwin were transferred to the Thumb. To the credit of MDOC, some PYO youth may actually be classified at a level higher than Level 2, but are purportedly treated as Level 2 inmates at least for programming.

The BMU is the PYO's equivalent to a segregation unit. Its cells are nearly identical to those in the Thumb's adult segregation units, although two youth are held in each BMU cell, except for inmates under 17, who are housed alone. However, unlike adult segregation, it is possible to earn one's way to less restrictive BMU segregation. There are, I was told, three levels with the BMU. "Core C" is the most restrictive level and is similar in almost every way to disciplinary or administrative segregation. Youth in "Core B" are allowed out of their cells to eat on the unit. Those in "Core A" eat first, off the unit. None of the youth on the BMU's Franklin B unit have televisions or other electronics, although I was told that at least some of them were supposed to be allowed to have them. (When I informed the Warden of this, she said it was against policy to deny them televisions, and promised to remedy it.) No programming is provided to youth in "Core C." Youth assigned there lose their spot in educational classes and

apparently may wait months to be placed back in class. Some youth in the BMU attend classes, assuming that they have a spot in class.

Core C notwithstanding, administrative segregation *per se* is not used on the Thumb's PYO. Apparently, any youth who would require administrative segregation is sent to the adult side of the Thumb or, perhaps more likely, reclassified and sent to another (e.g., level 5) facility.

Although the staff said that BMU placements are less than 30 days, we did identify at least one youth who had been in the BMU for over four months and stays of more than 30 days are apparently not unusual.

According to staff, youth in the BMU appear to receive slightly more educational opportunities than youth in segregation at Standish and Bellamy Creek or youth in segregation at the Thumb. I was told that these youth receive training in "Thinking for a Change," a cognitive behavioral program with which I am familiar in other jurisdictions. I was also informed by staff that even in Core C, inmates receive group and individual treatment. However, brief cell front interviews raised questions about the degree to which this actually occurs. Staff informed me that they complete an Individual Education Plan ("IEP") for every inmate with a learning disability, and that there is a minimum of 3 hours of instruction per week. It was reported that school attendance is required. I must confess to some confusion about the number of hours of school instruction given to youth in various categories. I did not spend the time necessary to clear up this confusion, as education was not my primary focus during these visits. This issue requires further investigation.

5. My interviews with youthful inmates.

I met with 13 youthful inmates out of their cells in rooms provided to us by the facilities. Plaintiff's counsel were present during these interviews. No prison staff or administrators were present, although they were nearby.

One youthful inmate I met at Standish (Youth 14.) has been in administrative segregation since October 2004 (including his time at MYCF), far beyond what I was told by staff was typical. He had been ticket free for at least 10 months, perhaps longer. He was understandably confused and upset by the facility's decision to continue his segregation. When I discussed this with the Warden, he told me that the Security Classification Committee felt that the youth showed a lack of contrition. I think that if the inmate's statements to the Committee that led to that belief were understood in the context of adolescent development it is likely that he would be considered a better candidate for return to the general population. At any rate, it is hard to see what interests, at least in terms of growth, development, and habilitation, are being served by keeping this ticket free young man in segregation any longer. With training, staff might better understand when to rely a youth's behavior rather than on his presentation – that is, when what he does is more important than what he says. Further, there is no evidence of any skill training during his period of segregation. If inmates are segregated due to an inability to safely do time, it makes little sense to prevent them from learning the skills necessary to allow them to return to general population. The myth that segregation alone will cause the acquisition of social skills, or even learning how to act appropriately in a prison, defies logic and is supported by no evidence. In my opinion, public policy and prisons safety would both be served by adding a social skills education component to segregation.

Another youth, Youth 2, has been in segregation at MYCF and Standish, continuously since January 2005.

All of the youth with whom I spoke carried "points" with them from MYCF at Baldwin. These points, they explained, affect their classification to security levels, the time they may spend in segregation if they receive tickets, their chances for parole, and the way they are treated by custody staff. Several told me that they felt that tickets they received at Baldwin in the weeks before it closed were particularly unfair. Although the Defendant's staff deny any unfair discipline at Baldwin, there is a clear perception of unfairness among the youthful inmates that extends beyond the complaining of unwarranted discipline. There is no dispute that points earned at MYCF are counted against youth in parole hearings and determinations.

Similarly, several of the youth told me that participation on the OPMHT, especially taking psychotropic medication, would be used against them when they came up for parole. They believed that being labeled as mentally ill produced negative points. At least one youth told me he had taken himself off of the OPMHT and off medication in the belief that it would improve his chances for parole. The Defendant's staff denied that receiving mental health services negatively impacted parole. However, it is clear to me that that message has not reached the prisoners. Nor is it clear that the staff perception is necessarily more accurate than that of the prisoners. This issue needs to be discussed with the Parole Board, including an accurate assessment of how many inmates have received discretionary releases while taking psychotropic medication.

6. General observations.

Like all prisoners, many youth in prison suffer from mental illness and/or developmental disabilities. Generally, studies demonstrate that as many as 20% of adult inmate populations

suffers from diagnosable mental disorders, a figure that does not include those diagnosed solely with substance abuse disorders. From my experience, these studies present a reasonable representation of the extent of mental illness in the American prison system and from my tours I saw no reason to believe Michigan is immune or even significantly different.

(Even at Standish, which I was told was a "mental illness free" prison, in a very short time I identified three inmates on the segregation unit who, I believe, even after only a brief cell-front conversation, are very likely to be psychotic. It appeared likely to me that the one mental health professional on staff, a PSU psychologist, could not perform the necessary "gatekeeper" functions for a facility with over 500 high security prisoners. Although I asked to speak with the psychologist, I was not provided that opportunity. In addition to inmates with previously unidentified mental illnesses and emerging mental illnesses that commence subsequent to incarceration, the psychologist at Standish is also responsible for responding to psychiatric or emotional crises, such as suicide gestures, attempts or threats that can occur in inmates with or without serious mental illnesses. This leaves very little time for the routine "gatekeeper" function that is envisioned for this lone mental health practitioner at Standish. Nor does this person appear to have any regular backup for his periods of vacation, sick leave, etc.)

Studies also show that inmates with mental health problems are more likely than those without to be charged with breaking facility rules – precisely the kinds of infractions that result in disciplinary sanctions in segregation units. Doris J. James & Lauren E. Glaze, Special Report: Mental Health Problems of Prison and Jail Inmates DOJ, Bureau of Justice Statistics (September 7, 2006). While I understand the sad necessity of segregating some prisoners, those whose inability to follow orders is at least in part due to their mental disabilities typically pose little threat to the prison, and their segregation often serves no useful purpose. Worse, segregation of

these inmates can cause iatrogenic harm, as some of them find their mental illnesses exacerbated by the segregation experience.

Most experts I know and studies I have read agree that the incidence of mental illness is even higher among incarcerated youth than among adult inmates. All of the young inmates I interviewed out of their cells were mentally ill and all had been or were in segregation. (Of course, they were selected by Plaintiff's counsel precisely for those reasons.) Most had long histories of involvement with the mental health system or, at least, of being treated with mental health medications, most frequently for Attention Deficit Disorder or Attention Deficit Hyperactivity Disorder.

Virtually without exception, correctional and correctional mental health experts recognize that adequate screening for suicide risk, mental illness, and developmental disabilities is essential. My impression from my investigation to date is that at least some and perhaps a significant number of youth with mental illnesses may be missed in the screening. I saw and met with inmates whom I believe have serious mental illness who are not being treated as such. It is not clear to me whether they were missed at the reception center, by PSU, or by the OPMHT. Nor is it clear to me whether their mental health needs were unidentified or simply ignored. This seemed particularly true for the several young inmates who had long histories with mental health medications prior to incarceration.

In June 2006, the Commission on Safety and Abuse in America's Prisons found that prisoners with mental illness are particularly susceptible to conditions in segregation. In the Commission's view, it may be impossible for some prisoners with schizophrenia, major depression, and other psychotic disorders to cope with segregation. In the Commission's view, extended stays in segregation may actually be harmful to these inmates and make it more

difficult to successfully treat them once they return to the general prison population or are released to the community. Nicholas de B. Katzenbach and John J. Gibbons, Confronting Confinement (2006). While adaptation to segregation varies idiosyncratically among inmates, many experts believe that the impact of segregation on youth is even more profound than on adults.

In my professional opinion, segregation increases the risk of exacerbation of the mental illness of inmates who are mentally ill when they are placed in segregation. Some inmates should not be placed in segregation because of their illness, while others may need to be removed from segregation depending upon their response to it.

Some inmates with serious mental illness, and even some youth, can in fact be housed in and can tolerate segregation. However, those inmates must receive appropriate mental health and other services and they should be carefully monitored so that any signs of decompensation or other severe negative effects of segregation can be identified early. These signs should result in prompt assessment and treatment.

For youth, it is particularly important that segregation, if it must be used, bear a relationship to its purpose, for example, to teach the youth to control behavior and "how to do time." Simply separating a young inmate from the general population for a long period of time, without more, will not be likely to improve subsequent behavior, and sometimes makes it much worse.

When screening inmates to determine if they are likely to respond especially badly to segregation, merely looking at diagnosis is not enough, particularly for young inmates. For example, a practice of screening out inmates with schizophrenia would be of little meaning for many youth, since the diagnostic criteria state that typical onset of the illness is between ages 18

and 25 and that symptoms must be sustained for at least six months. While serious mental illness or mental retardation might increase the risk of a bad response to segregation, inmates without such diagnoses might also have severe and negative responses. Further, predictive assessments at the beginning of the period of segregation are not sufficient, since it is difficult to predict which inmates with have severe negative reactions to the stress of segregations. In my opinion, regular brief assessments and periodic intensive assessments are required in order to respond quickly and effectively to an emerging psychological crisis in segregation.

Prisoners need human contact, natural light and other sensory stimulation, and regular exercise. Therefore, all experts that I know and all the literature recommend the use of rigorous screening and, more importantly, ongoing assessment to identify prisoners with mental illness who are not able to cope with the conditions in segregation. This requires facilities to have adequate trained and qualified staff to screen and identify such inmates, whenever these negative responses develop.

For those inmates who simultaneously pose a serious risk to the prison and a serious mental illness, it may be necessary to transfer them to inpatient psychiatric facilities, or to create secure treatment units inside prisons. Such units must be adequately staffed by mental health professionals and line staff, so that inmates with these characteristics can safely receive adequate psychiatric treatment. This should include therapy and activities that occur out of cell. Not only will this increase the safety and health of the prisoners and staff, but it will ease the transition from prison to the general community upon eventual release, thus promoting the public welfare as well.

Depression and hopelessness was a common theme among the youth I interviewed. While these may be common characteristics among inmates generally, the inmates I saw are still quite young, even minors.

7. My recommendations.

At the settlement conference, I made several recommendations, for settlement purposes only, that I characterized then as reasonable, practical, and inexpensive. I reiterate the recommendations here. I believe that the implementation of these recommendations would improve the lives of young inmates without in any way compromising the safety of the inmates or staff or the integrity of the penological purposes of the facilities. Nor do I believe that any of these recommendations are likely to result in significantly increase expense. Indeed, it is my opinion that these straightforward changes would result in fewer injuries to staff (thus saving money) and inmates and would increase the likelihood of young inmates' successful reintegration after release.

Discipline and punishment.

Based on what I have seen to date, I believe that the structure of the equivalent to the "insanity defense" to disciplinary tickets appears appropriate as it is set forth in MDOC policy. However, I am concerned about the qualifications and training of custody staff who give tickets and the hearing officers who decide the punishment to youthful inmates. Therefore, I recommend training for hearing officers on the relationship between mental illness, adolescent development, and prison misconduct; and that the hearing officers be required to consult with the OPMHT for anyone who is under 18 and receives a ticket that could result in segregation. For youth between 18 and 26, the hearing officer should have the option of consulting with the OPMHT if there is any evidence of mental illness. For any youth with an IEP, the hearing officer should be required

to consult with the prison's special education teacher. Current policy requires consultation with the OPMHT only if the inmate raises an "insanity defense" to the ticket, which may not occur due to ignorance, an unwillingness or inability to acknowledge one's mental illness, or embarrassment.

Also, in regard to discipline, I recommend that wardens and other appropriate administrators receive training on adolescent development and its implications for behaviors that may result in discipline. The training should include the implications of adolescence and development on mental health and the effects of segregation and isolation on young people.

Drawing from this training, each facility should develop a plan for addressing the behavior of youthful inmates and for teaching better behavior. The facility mental health and educational staff should be involved in the development of this plan. Any mental health staff member who works with youth should receive special training in adolescent mental health and development. If possible, I would recommend recruiting a child and adolescent psychologist into any current or future vacancies, especially at Thumb. Training of custody staff is addressed in the next paragraph.

Specifically, I recommend creation of a multi-level behavioral program in segregation. While I believe that such a program would be well advised in every segregation setting, for the purposes of this matter, it is especially important for youth housed in segregation environments. This program should allow inmates to control aspects of their conditions of confinement by demonstrating appropriate behavior, and should include some instruction in how to manifest such behaviors. For most inmates, this should allow them to control the conditions and duration of their segregation, by working their way back to general population.

Mental health services.

In my opinion, it is essential that custody staff be trained to identify symptoms of mental illness, to spot mental health needs, and how to work with youth with mental illness. I understand that this training will necessarily compete with other compelling training needs. However, there are many excellent training packages, and some could be prepared for use at shift changes.

Correctional officers who work with inmates with serious mental illness should receive specialized training, and officers who work with youth should receive training in adolescent development.

If my preliminary observations were correct, it may be necessary to improve identification of developmental disabilities at the reception center and throughout an inmate's incarceration.

I recommend that any youthful inmate who identifies or is known to have been hospitalized for mental illness or to have taken mental health medication (including medication for ADD, ADHD, or behavioral issues) automatically be referred to a psychiatrist for evaluation.

It is difficult to understand why any facility would have no OPMHT staff, especially one with large numbers of segregation inmates. Facilities like Standish should have at least one OPMHT clinician and access to a psychiatrist, and if it does not have a OPMHT, it should have additional PSU staff, including at least one person with doctoral level qualifications to be better able to identify mental health needs. Inmates at these facilities should also have access to a psychiatrist. This is particularly important for the youth who are subject of this case. In areas where psychiatric staffing is not possible, telemedicine may provide an adequate alternative.

All mental health staff (PSU, OPMHT, and health team staff who administer psychiatric medications) should receive annual training on youth and adolescent mental health issues. Wardens and other top administrators should also participate in this training.

There should be policies that require mental health staff to respond quickly to requests from youthful inmates to see mental health staff.

Disciplinary and Administrative Segregation and the BMU.

As I understand current MDOC policy, if the inmate has a mental health treatment history, and they are on the OPMHT or on psychotropic medication, they should be seen and evaluated by a mental health professional (a social worker, psychologist, psychiatric nurse, or psychiatrist) no more than one business day after being placed in segregation. That is an appropriate policy. That mental health professional should recommend an appropriate placement, which could include a mental health unit, and then the inmate should be transferred there within three business days. However, just because an inmate is deemed likely to adapt to segregation is no guarantee that he will. Ongoing assessment is required, preferably by doing weekly cell-to-cell "rounds" on segregation units.

If the inmate has a serious mental illness or receives psychotropic medication and stays in segregation, current policy requires a management plan within three days after going to segregation. This plan should include frequent follow up by a mental health professional while they are in segregation. My impression is that the plans tend to be forms that are not at all individualized to the inmates' needs. In one facility, plans were posted on the inmates' cell doors, a very good idea. However, this was apparently limited to inmates on suicide precautions (and not for those with serious mental illnesses) and was not duplicated at any other facility I visited.

To ensure that those youth who are segregated are released as soon as possible, I recommend that a member of the OPMHT be a member of the Security Classification Committee to address whether continued segregation is contraindicated for the inmate's mental health needs. Alternatively, the Classification Committee could be required to consult with the OPMHT at regular intervals.

In addition to at least weekly mental health rounds, any youth who is in segregation for 30 days should be seen outside his cell by a qualified mental health professional. A similar review should take place after 60 days. Current policies require that if an inmate is confined in segregation for more than 30 days, he should be interviewed by a mental health professional, and he should be given a psychological assessment. There are no requirements as to the scope, intensity, or setting of this evaluation.

There should be more explicit segregation reviews with an emphasis on mental health issues, and the criteria for release should be more clear and better known to the inmates. To the extent that inmates perceive the termination of their segregation as arbitrary and beyond their control, it will contribute to feelings of hopelessness that are counter-productive and unlikely to improve the inmate's behavior.

There should be graduated levels of segregation, with progression through the levels based on behavior. At each progressive level, inmates should have slightly higher behavioral expectations and slightly additional privileges. For most inmates, this should provide a way to "work themselves out" of segregation in a predictable fashion. This will create an environment of individual responsibility, where release from segregation is no longer perceived as an arbitrary process, but instead is the predictable result of the inmate's own behavior. (I note that in some cases of especially significant institutional dangers, such as inmates who have made lethal

attacks on staff, there may be limitations to how far an inmate may be allowed to progress, but even in these cases the inmate will have something to lose by acting in an inappropriate manner.)

Mental health rounds in segregation should be conducted at least weekly for all segregated inmates, regardless of the length of their segregation. These rounds should be completed by a QMHP, and any signs of psychological distress should result in a more intensive, preferably face-to-face assessment outside of the inmate's cell.

Meaningful instruction and educational opportunity should be available to youth in segregation. This includes sufficient time one to one with a teacher.

In regard to the BMU in particular, I recommend access to MH groups and special education while in BMU. There should also be a requirement that if a youth cannot be moved out of Franklin B due to bed space but they have satisfied the BMU requirements, their privileges (like electronics) should be restored.

Parole eligibility.

I recommend that there be a program through which youth transferred from Baldwin can earn back points they earned there through good behavior at the new facility. This will provide an opportunity for a fresh start, provide some hope for the future, and perhaps increase the likelihood of better behavior and successful reintegration.

I wish to reiterate my appreciation to the Wardens and their staff members for their candor and hospitality during my visits. I believe that the changes suggested in this document will assist them in managing their prisons in a safe, fair, secure, and psychologically appropriate fashion.

Respectfully submitted,

Date: November 3, 2006

Joel Dvoskin, Ph.D.

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1996 - Current
Asst. Professor (Adjunct) - University of Arizona College of Law
Asst. Professor (Clinical) - University of Arizona College of Medicine, Dept. of Psychiatry

1986 - Current
Assistant Clinical Professor - New York University Medical School, Dept. of Psychiatry

2000 - Current
Assistant Clinical Professor - Louisiana State University Medical Center

LICENSE:

Arizona Board of Psychologist Examiners, License #0931
New Mexico State Board of Psychologist Examiners, License #0904

PROFESSIONAL EXPERIENCE:

September 1995 - Current

Full-time private practice of forensic psychology, providing expert testimony on civil and criminal matters, and consultation in the provision of mental health and criminal justice services, and workplace and community violence prevention programs.
Duties: Provide expert testimony, consultation, training, and public speaking services to federal, state, and local governmental agencies, corporations and attorneys, including the following areas:

- Police misconduct
- Conditions of confinement and hospitalization
- Architectural design of psychiatric and secure psychiatric buildings
- Workplace violence prevention and crisis response
  - Working with labor organizations
  - Safely managing corporate layoffs
- Psychological autopsy
- Suicide prevention
- Mental health services in correctional and criminal justice settings
- Mental health services to juvenile correctional facilities
- Stalking
- Assessing and preventing the risk of violent behavior
- Administration of public mental health and criminal justice services

September 1995 - Current

Associate, Threat Assessment Group, Inc., Newport Beach, California.
Duties: Provide consultation and training in workplace violence prevention and crisis management to governmental and corporate organizations.

September 1995 - Current

Associate, Park Dietz & Associates, Inc., Newport Beach, California.
Duties: Forensic psychological services and expert testimony

March 1995 - August 1995

Acting Commissioner, New York State Office of Mental Health.
Duties: Under the direct supervision of the Governor, served as C.E.O. of the largest agency of its kind in the United States, with an annual budget of more than $2.4 billion. The agency employed over 24,000 people and directly operated 29 institutions, including adult inpatient and outpatient psychiatric facilities, children's psychiatric hospitals, forensic hospitals and research institutes. The Office of Mental Health also licensed, regulated, financed, and oversaw more than 2,000 locally operated inpatient, emergency, outpatient, and residential programs in collaboration with 57 counties and New York City.

November 1984 - March 1995

Director, Bureau of Forensic Services (1984-1988) and Associate Commissioner for Forensic Services (1988-1995), New York State Office of Mental Health.
Duties: Line authority for inpatient services at three large forensic hospitals and two regional forensic units, including services to civil, forensic and correctional patients; line authority for all mental health services in New York State prisons (serving more than 60,000 inmates); responsibility for innovative community forensic programs including suicide prevention in local jails, police mental health training, and mental health alternatives to incarceration.

December 1984 - July 1985

Acting Executive Director, Kirby Forensic Psychiatric Center.
Duties: Founding C.E.O. for new maximum security forensic psychiatric hospital in New York City.

July 1984 - November 1984

Acting Director, Office of Mental Health, Virginia Department of Mental Health and Mental Retardation (held concurrently with permanent position as Director of Forensic Services).
Duties: Supervision of budget and certification of all community mental health programs statewide; statewide policy development in all program areas related to mental health; Executive Secretary to Virginia Mental Health Advisory Council.

July 1983 - November 1984

Director of Forensic Services, Virginia Department of Mental Health and Mental Retardation.
Duties: Design and coordination of statewide delivery system of institutional and community treatment and evaluation of forensic patients; management of the contract for the University of Virginia Institute of Law, Psychiatry and Public Policy; departmental liaison to Virginia Dept. of Corrections and other criminal justice agencies; develop statewide plan for delivery of mental health services to D.O.C. inmates; statewide Task Force on Mental Health Services in Local Jails.

August 1982 - July 1983

Psychologist, Arizona Correctional Training Center, Tucson, Arizona.
Duties: Supervision of psychology department; direct clinical treatment and evaluation services.

April 1982 - July 1982

Acting Inmate Management Administrator, Arizona State Prison Complex, Florence, Arizona.
Duties: Direct supervision of inmate records office; inmate classification and movement; correctional program (counseling) services; psychology department; hiring of all new correctional officers. (NOTE: During this period, I also maintained all duties of my permanent position as Psychologist (below).

October 1981 - July 1982

Psychologist, Arizona State Prison Complex, Florence, Arizona.
Duties: Supervision of Psychology Department for complex consisting of five prisons; direct clinical treatment and evaluation services.

November 1980 - October 1981
Psychology Associate, Arizona State Prison Complex, Florence, Arizona.
Duties: Direct clinical treatment and evaluation services.

August 1980 - November 1980
Psychological consultant to the Massachusetts Department of Correction.
Duties: Consultation to Director of Health Services; direct clinical treatment and evaluation services at Walpole and Norfolk State Prisons.

January 1980 - November 1980
Psychologist - Tri-Cities Community Mental Health Center, Malden, Massachusetts

August 1979 - August 1980
Pre-Doctoral Intern in Clinical Psychology, McLean Hospital, Belmont, Massachusetts; and Fellow in Clinical and Forensic Psychology, Harvard Medical School, Cambridge, Massachusetts, and Bridgewater (Massachusetts) State Hospital

1978-1979 Psychology Extern, Pima County (Arizona) Superior Court Clinic

1977-1978 Psychology Extern, Palo Verde Hospital, Tucson, Arizona

1976-1977 Psychology Extern, Arizona Youth Center (now Catalina Mountain School), Tucson, Arizona

1975-1976 National Institute of Mental Health Trainee

1973-1975 United States Peace Corps Volunteer, Senegal, West Africa

1970-1995 Coach, Dean Smith's Carolina Basketball School, Chapel Hill, N.C. (1-3 weeks each summer)

SELECTED CONSULTATION CLIENTS:

Federal Government -

National Institute of Mental Health
United States Secret Service
United States Department of Justice, Civil Rights Division
National Institute of Justice
National Institute of Corrections
Center for Mental Health Services
Substance Abuse and Mental Health Administration
United States Secret Service

State and Local Governments -

Alabama	Hawaii	Nevada	Tennessee
Arizona	Illinois	New Jersey	Texas
Arkansas	Kentucky	New Mexico	Utah
California	Louisiana	New York	Vermont
Colorado	Maine	North Carolina	Virginia
Connecticut	Maryland	Ohio	Washington
Delaware	Massachusetts	Oregon	West Virginia
Dist. of Columbia	Michigan	Pennsylvania	Wyoming
Florida	Missouri	Puerto Rico	
Georgia	Nebraska	South Carolina	

International Clients -

Province of Ontario
Correctional Service of Canada
Province of British Columbia

Selected Corporate Clients -

American Express
Amgen
Boise Cascade
Borden Foods
Chase Manhattan Bank
Corning, Incorporated
DaimlerChrysler Corporation
General Dynamics
Honeywell
Johnson and Johnson
Kraft Foods
Levi Strauss
Macy's
Motorola
National Basketball Players Association
National Basketball Association
National Semiconductor
Nationwide Insurance
Nordstrom
Oracle Corporation
Pillsbury
Sony Corporation
State Farm Insurance
Texas Instruments
3M Corporation
University of Arizona
Warner-Lambert Pharmaceuticals

Professional Organization Clients –

American Psychiatric Association - Committee on Correctional Psychiatry
American Correctional Association
Arizona Bar Association
American Bar Association

Federal Court Expert and Monitor –

Independent Expert to monitor a Federal Court settlement agreement at the Bernalillo County (N.M.) Detention Center in Albuquerque.

Federal Court Monitor (one of two) of a settlement agreement regarding the Institute of Forensic Psychiatry at the Colorado Mental Health Institute – Pueblo.

Federal Court Monitor (one of three) of a settlement agreement regarding the Forensic Unit at the Western State Hospital in Tacoma, Washington.

Architectural Consultations -

Dr. Dvoskin has served as design consultant for major renovations and new construction of a number of state, federal, and territorial psychiatric facilities during his long career. The following is a partial list of these projects:

New York - As part of his duties as Associate Commissioner of Mental Health for the state of New York, Dr. Dvoskin oversaw design of major renovations to Mid-Hudson Psychiatric Center, a 300 bed forensic psychiatric hospital in Middletown, NY. Completion of this project resulted in significant reductions in violent incidents at this facility.

Georgia - As part of a federal class action, plaintiffs and defendants agreed to ask Dr. Dvoskin to assess suicide hazards at six of Georgia's large state prisons, resulting in cost-effective, potentially life saving physical plant changes to rooms in which suicidal inmates were housed.

Louisiana - Again, at the request of plaintiffs and defendants, Dr. Dvoskin performed a comprehensive assessment of suicide hazards in the state's juvenile correctional facilities.

Puerto Rico - Dr. Dvoskin served as design consultant for a new correctional psychiatric center, which cost less than renovation of the existing building, which was the basis for a finding of unconstitutional conditions.

Michigan - Dr. Dvoskin assisted the state of Michigan, which was involved in constitutional litigation regarding its prison mental health system, in creating a system within the Department of Mental Health. He also served as design consultant for new beds added to a state forensic psychiatric facility.

Maryland, Florida, and Maine - Dr. Dvoskin served as consultant to Commissioners of Mental Health, including consultation on the physical plants of forensic and civil psychiatric hospitals.

Delaware - Dr. Dvoskin served as design consultant for the new forensic wing of the state's psychiatric hospital.

Colorado - Dr. Dvoskin served as design consultant for the state's new forensic psychiatric hospital; a design which combines a sense of privacy and dignity among patients without sacrificing the visibility needed in order for staff to maintain safety.

Washington, DC - Dr. Dvoskin served as consultant to two Federal Receivers, then to the Commissioner of Mental Health, in a variety of areas. These included an assessment of the number of beds needed, then to assist in a Capital Plan for the entire District of Columbia Mental Health System. Most recently and currently, Dr. Dvoskin serves as design consultant for the creation of a brand new Saint Elizabeths Hospital, to replace the entire civil and forensic hospital campus. The design of this facility, which is nearly completed, included an innovative consumer advisory panel, facilitated by Dr. Dvoskin, which had input into every phase of the project's design.

North Carolina – Consultant to architectural renovation of forensic unit at Broughton State Hospital.

BOARD MEMBERSHIPS:

Editorial Boards	Journal of the American Academy of Psychiatry and the Law (former) Journal of Mental Health Administration Behavioral Sciences and the Law Journal of Aggression, Maltreatment, and Trauma (former) Psychological Services Journal of Threat Assessment (former) Law and Human Behavior
Research Advisory Board	United States Secret Service
Advisory Board	National Center for State Courts, Institute on Mental Disability and the Law
Member	White House Panel on the Future of African-American Males – 1995
Member	American Bar Association Task Force on Capital Punishment and Mental Disability

PUBLICATIONS:

Dvoskin JA & Metzner JL (2006).
Commentary: The Physicians Torture Report. Correctional Mental Health Report. Kingston, NJ. Volume 8, No. 1.

Schlank A & Dvoskin JA (2006).
Similar Statutes, Different Treatment Needs -- A Comparison of SVP and Mentally Ill Populations. In Schlank, A. (Ed.) The Sexual Predator, Volume 3: New York, NY: Civic Research Institute.

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Two Sides to Every Story: The Need for Objectivity and Evidence. Journal of the American Academy of Psychiatry and the Law. Vol. 33, No. 4, 482-483.

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Metzner JL and Dvoskin JA (2004) Psychiatry in Correctional Settings, in Textbook of Forensic Psychiatry. Robert R. Simon MD and Lisa H. Gold, MD (editors). Washington, DC: American Psychiatric Publishing, Inc.

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Dvoskin, JA, Spiers, EM, Metzner, JL, and Pitt, SE (In press)
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Architectural design of a secure forensic state psychiatric hospital. Behavioral Sciences and the Law, Vol. 20, No. 5. Pages 481-493.

Dvoskin, J.A. and Petrila, J. (2002).
Commentary: Behavioral Health Professionals in Class Action Litigation -- Some Thoughts on the Lawyer's Perspective. Journal of the American Academy of Psychiatry and the Law. 30:1

Dvoskin, JA, and Heilbrun, K. (2001)
Risk assessment and release decision-making: Toward resolving the great debate. Journal of the American Academy of Psychiatry and the Law Vol. 29:6-10

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The Transition from being an inmate. In Steadman, Henry J. and Cocozza, Joseph J. (Editors), Mental Illness in America's Prisons. Seattle: National Coalition for the Mentally Ill in the Criminal Justice System.

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AIDS Related Dementia and Competency to Stand Trial: A Potential Abuse of the Forensic Mental Health System. Bulletin of the American Academy of Psychiatry and the Law, Volume 18, No. 4.

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Dvoskin, Joel A. (1989)
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Dvoskin, J.A. and Powitsky, R. (1984)
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Dietz, Park E. and Dvoskin, Joel A. (1980)
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Dvoskin, Joel A. (1979)
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PROFESSIONAL AFFILIATIONS:

American Psychological Association (Fellow)
American Association of Correctional Psychologists
American Psychology - Law Society (Fellow)
American Correctional Association
National Association of State Mental Health Forensic Directors - Chairman 1986-1988
American Correctional Health Association
American Jail Association